CHESAPEAKE REGIONAL HEALTHCARE

Chesapeake Regional Healthcare Financial Assistance Application

Applicants must complete all required documents in black or blue ink and submit in the same mailing envelope or fax to: Fax #: (757) 312-6591 Mailing Address: ATTN: Financial Counselor 736 Battlefield Boulevard, North Chesapeake, VA 23320.

Patient Name:	**Date of Birth:**	**Account #**
Address:	**Social Security #:**	**Phone #:**
Marital Status:	**Employer:**	**Spouse employer:**

Check the box if the patient is a minor ☐

Unemployment Verification: *I attest that I have been unemployed since _____and my last employer was_____.*

FAMILY MEMBERS: *List spouse or dependents as listed on tax return.*

Name	Age	Relationship

PLEASE CHECK IF YOU RECEIVE OR CURRENTLY HAVE THE FOLLOWING RESOURCES AND PROVIDE THE CURRENT VALIDATION:

☐ WIC ☐ SNAP (food stamps) ☐ SUBSIDIZED/LOW INCOME HOUSING ☐ HOMELESS ☐ PLAN FIRST

Please answer the following questions below and provide the required documents:

Please answer all questions listed below	If **YES**, please provide the following documents for **EACH** member of the household
Do you have health insurance? ☐ Y ☐ N **If no**, have you attempted to apply for Medicaid in the last 6 months and been denied? ☐ Y ☐ N (Please provide validation letter)	**UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE.**
Is any member of your household **employed**? ☐ Y ☐ N	3 current pay stubs **or** tax return from the most recent tax year.
Is any member of your household **self-employed**? ☐ Y ☐ N	Complete tax return packet from the most recent tax year.
Is any member of your household receiving **unemployment benefits**? ☐ Y ☐ N	Benefit letter or Unemployment printout from State website.
Is any member of your household receiving **social security**? ☐ Y ☐ N	Social Security benefit letter
Is any member of your household covered by **Medicare ?** ☐ Y ☐ N	Provide CRH Medicare expense sheet
Does any member of your household receive **alimony or child support**? ☐ Y ☐ N	Court order document.
Does any member of your household have a **checking, savings, or money market account?** ☐ Y ☐ N	Attach complete copy of current 30-day statement for each account.
Does any member of your household have **any other source of income?** ☐ Y ☐ N	GI bill, dividend, rental property, etc.... Attach current statement(s)

I certify the above information is correct and true. I authorize Chesapeake Regional Healthcare to verify this information with employers and other agencies. I understand this information is subject to review by federal and/or state agencies. I understand and acknowledge that I must provide required documents in order to complete this application. Incomplete applications will be denied.

*****PLEASE NOTE APPLICATION WILL NOT BE CONSIDERED ON ACCOUNTS THAT ARE WITH A COLLECTION AGENCY. *****

Signature: _____ **Date:** _____

It is the patient's responsibility to confirm we received your application and documents. (757)312-6281