



**APPLICATION
FOR
FINANCIAL ASSISTANCE**

PLEASE MAIL COMPLETED FORM TO:
 Centra Health Patient Accounting Services
 PO Box 2496
 Lynchburg, VA 24505-2496
 Attention Customer Service

STEP 1: COMPLETE INFORMATION BELOW (SEE REVERSE SIDE FOR INSTRUCTIONS)

Patient Name:	Soc. Sec #:
Address:	Birth Date:
City, State, Zip	Medical Record #:

STEP 2: FILL OUT INCOME/ASSET INFORMATION **If there is no reported income, explain your means of support**

Family Members-Include self and immediate family only	Age	Relation to head of household	Gross monthly income (pretax)	Employer Name	Employer Phone #

Checking Acct # Yes / No (circle)	Bank Name: Location:	Balance: \$
Savings Acct # Yes / No (circle)	Bank Name: Location:	Balance: \$
Stocks, Bonds, IRA's, 401K, CD's, etc. Yes / No (circle)	Bank Name: Location:	Balance: \$

Real Estate Property Address:	Rent / Buy (circle)	Total acreage:	Monthly Payment: \$
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Taxable Personal Property: Yes / No (circle one) List cars, boats, trucks, motorcycles, campers, mobile homes, etc.

Item:	Make Model:	Year:	Owner:	Amount Owed: \$	Value: \$

Do you have a life insurance policy for you or any dependent over 21 with a cash-in value over \$1,500? Yes / No (circle)		
Name of insurance company:	Policy #:	Cash-in value?

Are you currently working with an attorney or insurance carrier on an accident claim? Yes / No
Name of attorney or insurance company _____ Telephone Number _____ Date of accident _____

STEP 3: FILL OUT EXPENSES & LIABILITIES INFORMATION

Mortgage / Rent	Amount:
Total Utilities (telephone, cable, water, sewer, etc...)	Electric Amount: Other Amount: Other Amount:
Transportation	Loan Payment Amount: Monthly Gas Amount:
Food	Amount:
Medical	Prescription Amount: Other Amount:
Other Loans	Amount:
Credit Cards	Amount:
Other (List)	Amount:
Total:	
Discretionary Totals: (Total Income - Total Expenses)	

**CONFIDENTIAL
CENTRA HEALTH
APPLICATION FOR ASSISTANCE FORM**

If unemployed, please provide the date employment was terminated: _____

Do you have Medicaid or SLH Yes / No *If yes, please provide copy of Medicaid card or SLH approval.
Have you ever applied for Medicaid? Yes / No *If yes, please list where and when: _____

DECLARATION: THE INFORMATION PROVIDED ABOVE IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, COMPLETE, ACCURATE AND TRUE. I AUTHORIZE THE RELEASE OF ALL INFORMATION WHICH CENTRA HEALTH MAY NEED TO DETERMINE WHETHER I QUALIFY FOR FINANCIAL ASSISTANCE THROUGH CENTRA HEALTH'S INDIGENT CARE PROGRAM OR ANY OTHER FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, INCLUDING VERIFICATION OF MY SALARY OR WAGES, THE BALANCE OF ANY BANK ACCOUNTS THAT I MAINTAIN, THE CASH-IN VALUE OF ANY LIFE INSURANCE POLICY, STOCKS OR BONDS WHICH I POSSESS, AS WELL AS THE VALUE OF ANY REAL OR PERSONAL PROPERTY WHICH I OWN OR AM PURCHASING, SHOULD I BE REFERRED TO A FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM I AUTHORIZE CENTRA HEALTH TO RELEASE AND OBTAIN ALL INFORMATION NEEDED TO DETERMINE ELIGIBILITY FOR THAT FUNDING.

***SIGNATURE(S) REQUIRED**

Applicant's signature:	Date:
Spouse's signature:	Date:

- STEP 1:** Complete patient information. Please fill out all information concerning the patient completely.
STEP 2: Fill out income and asset information. This includes income from your employer, social service aid (food stamps, ADC, General Relief), government aid (social security, VA benefits), and all other income. If any child is 18 years or older, a separate form is required.
STEP 3: Fill out monthly expenses and liabilities. This includes mortgage payment, rent, utilities, loans, medical, or other expenses.

Who is head of household? This is the member of the family who provides food and shelter for the applicant. The applicant can also be the head of household. A non-family member should not be listed in the family section.

IN ORDER FOR CENTRA HEALTH TO COMPLY WITH STATE GUIDELINES, EACH OF THE ITEMS YOU HAVE LISTED ON THE FRONT OF THIS APPLICATION WILL REQUIRE PROOF OR DOCUMENTATION. PLEASE DO NOT SEND IN YOUR APPLICATION UNLESS YOU HAVE ATTACHED ALL DOCUMENTATION NEEDED. ALL INFORMATION MUST BE RETURNED AS SOON AS POSSIBLE OR YOU WILL BE RESPONSIBLE FOR YOUR CHARGES IN FULL.

The following are types of documentation needed. Please check each one to see which ones may apply to your situation: (copies only please, originals will not be returned.)

- **PAY CHECK STUBS:**
If you are employed, you must provide 1 (one) month's worth of your pay stubs – not more than 3 months old. If your stubs are not available, you need to provide a letter from your employer stating 1 (one) months gross salary.
- **UNEMPLOYED:**
Forms verifying weekly benefits, General Relief check, ADC check, trust fund allotments, child support check and alimony.
- **OTHER RESOURCES:**
Copy of retirement benefits, General Relief check, ADC check, trust fund allotments, child support check and alimony.
- **GOVERNMENT BENEFITS:**
Letter confirming or denying Social Security, SSI, VA or other government benefits, photo copy of check(s) or bank statement showing automatic deposit.
- **SEASONAL EMPLOYMENT:** Please provide Centra Health income verification form.
- **SELF EMPLOYED:** Provide your current year Federal Income Tax return.
- **LETTER OF SUPPORT:** Letter verifying support from family or friends (when no income is reported or not enough to show support.)
- **SOCIAL SERVICES:**
Approval, denial, or pending status from your local department or social services. Any letters confirming receipt of housing and/or food stamps monthly benefit amount.
- **BANK STATEMENTS:** Most recent savings and/or checking account statement(s) from the bank or credit union.
- **SICK LEAVE:**
Statement from doctor stating dates you are unable to work. Statement from employer indicating paid sick leave or if you are on leave without pay, year-to-date gross and hire date.
- **STUDENTS:** Scholarship, loan, workstudy, stipend, tuition, assistantship and grant award amounts.