CARILION CLINIC

EMPI NUMBER:

Financial Assistance Application

Complete this form entirely to help us determine your eligibility for financial assistance. Return the completed form with copies of supporting documents to Carilion Clinic, CASB Suite 625, P.O. Box 40032, Roanoke, VA 24022-0032, or fax to 540-224-5444 or email to billingservice@carilionclinic.org.

Your application for Financial Assistance is not complete without the information listed below. **Please do not send original documents as we are unable to return these documents to you.**

- ☐ **Proof of Income.** (Copies of last month's pay stubs, letter from employer showing gross wages, SSA Award letter, unemployment award letter, pension letter, etc. If you are self-employed, attach a copy of your previous year's federal tax return.)
- ☐ **Proof of Assets**. (Copies of last month's checking, saving, credit union, CD, Christmas Club, Pay Card, HSA, stocks, bonds, Trust fund statements and proof of any other asset. **Do not include IRS recognized retirement accounts such 401k, 403b, defined benefit pension plans, etc.).**
- ☐ **Proof of value of other real property (not principal residence) and loan pay-off amount.**

About the Patient		
Patient's Full Name	**Date of Birth**	**Marital Status**
Physical Address	**City, State, Zip**	
Mailing Address (if different)	**City, State, Zip (if different)**	
Home Phone #	**Mobile Phone #**	
Employer's Name	**Employer's Phone #**	
Health Insurance and/or Medicaid	**Subscriber ID/Subscriber Name**	

List EVERYONE living in the home including patient noted above. Include the patient, spouse, parents, legal tax dependents, and siblings living in the home.

Please List All Family Members			
Name	**Date of Birth**	**Relation to Patient**	**Income** Record Gross income from wages, Social Security, retirement, pensions, VA, unemployment, or any other source excluding capital gains/losses, and public assistance such as food and housing subsidies, and educational assistance

Statement of Support	If you reported $0 income for your family, provide a brief explanation of how you meet your basic living needs. _____ _____

DO NOT LEAVE BLANK.

Property	Address	Ownership	Tax Value	Loan Balance	Mortgage Company
Non-home Real Property		☐ Own ☐ Rent			
Non-home Real Property		☐ Own ☐ Rent			

DO NOT LEAVE BLANK. **List all accounts.**

Banking/ Investments		Institution	Balance	Account Holders
Checking ☐YES ☐NO	1			
	2			
Savings ☐YES ☐NO	1			
	2			
Pay Card, HSA ☐YES ☐NO				
CD, Christmas Club ☐YES ☐NO				
Investment Funds ☐YES ☐NO				
Stocks/Bonds ☐YES ☐NO				
Other (Trusts or other assets)				

Acknowledgment and Signatures

I understand that the information provided in this application will be used to evaluate my ability to pay my medical bills.

I agree to cooperate with Carilion Clinic in pursuing reimbursement from any available insurance or medical payment programs. I understand that all or part of my indebtedness to Carilion may be reduced if I qualify under the current Financial Assistance Guidelines. I hereby certify that the information contained in this form is accurate, and I authorize any and all parties to release any information necessary to confirm this information.

I further authorize and agree that Carilion may obtain credit reports with respect to me. In exchange for Carilion's consideration of this application, I reaffirm that I am financially responsible for the accounts upon which I have applied for assistance.

Signature:	Printed Name:
Relationship to Patient:	Date:

If you need help completing this application, call Billing Customer Service at 1-866-720-3742 (toll-free). Or visit the payment center at 1502 Williamson Road N.E., Suite 100, Roanoke, VA 24012, Monday-Friday, 8 a.m. - 6 p.m.
For more information, visit CarilionClinic.org/billing/financial-assistance.