



<i>Internal use only</i>	
MRN	STATUS
HH	COUNTABLE RP EQUITY
GROSS ANNUAL INCOME	TOTAL LIQUID ASSETS

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 CASB, Suite 625, P.O. Box 40032, Roanoke, VA 24022-0032, or fax to 540-224-5444 or email to billingservice@carilionclinc.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, SSA Award letter, unemployment award letter, pension letter, etc. If you are self-employed, attach a copy of your previous year's federal tax form.)
- Copies of last month's checking, saving, CD, IRA statements and proof of any other asset listed.**
- Proof of value of real property and loan pay-off amount.**
- Copy of both front and back of your health insurance card.**

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 Name	Subscriber ID/Subscriber Name	

Family Members include the patient, spouse and legal dependents under age 18 living in the home. If the patient is a minor, then the parents and siblings under age 18 living in the home are family members.

Please List All Family Members				
Name	Date of Birth	Relation to Patient	Income Gross income from wages, Social Security, retirement, pensions, VA, unemployment or any other source.	
1				
2				
3				
4				
5				
6				

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
Primary Residence		<input type="checkbox"/> Own	<input type="checkbox"/> Rent			
Other Property		<input type="checkbox"/> Own	<input type="checkbox"/> Rent			
Other Property		<input type="checkbox"/> Own	<input type="checkbox"/> Rent			

DO NOT LEAVE BLANK. List all accounts.

Banking/ Investments	Institution	Balance	Account Holders
Checking <input type="checkbox"/> YES <input type="checkbox"/> NO	1		
	2		
Savings <input type="checkbox"/> YES <input type="checkbox"/> NO	1		
	2		
CDs <input type="checkbox"/> YES <input type="checkbox"/> NO			
401k/403b/IRA <input type="checkbox"/> YES <input type="checkbox"/> NO			
Stocks/Bonds <input type="checkbox"/> YES <input type="checkbox"/> NO			
Other (trust fund, etc.)			

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 540-510-6300 or 1-866-720-3742 (toll-free). Or stop by Carilion Payment Center, 1502 Williamson Road, N.E., Roanoke, VA 24012, Monday-Friday, 9 a.m. - 6 p.m.

For more information, visit CarilionClinic.org/billing/financial-assistance.