FINANCIAL ASSISTANCE APPLICATION 2020

Carteret Health Care extends this application to you for our Financial Assistance Program. This program is offered to all patients with or without health insurance who have outstanding balances at Carteret Health Care. Please complete application and return with all requested supporting documentation in order to see if you qualify for an adjustment. The adjustment percentage is based on the information you provide in combination with the Federal Income Guidelines.

THIS PROGRAM ONLY COVERS CARTERET HEALTH CARE BILLS

Below you will find details to required documents listed on the Supporting Documentation Worksheet of the Financial Assistance Application. Please refer to the Supporting Documentation Worksheet, (page 2) to locate the number which best describes your means of income. You will need to provide all required documents listed for your means of income.

Explanation of additional documents that maybe required are as follows:

A copy of your complete ***2019*** Federal Income Tax return 1040 Form ***and*** supporting schedules, (Schedule C, Schedule 1 and/or Schedule D/E etc.)

A Medicaid screening is required for applicants. Once you have been screened, please provide an approval letter or denial letter with your application. Please contact your local Department of Social Services for Medicaid screenings. Documentation of a Medicaid screening from the Carteret Health Care Advocatia Field Representative, (252) 499-6570, will also be accepted.
All letters must be dated within the last 90 days.

If you ***Did Not*** **and** ***Do Not Plan*** **to file Federal Income Taxes for** ***2019*** due to limited or no income, please sign and have notarized the 'Statement of Non-Filing of 2019 Taxes' in front of a notary.
If you ***Do Not have Income*** to report and are being financially supported by another person, you must have your supporting party sign the 'Statement of Non-Filing of 2019 Taxes', with you, in front of a notary. Financial support includes shelter, food, expenses, etc. A copy of the supporting party's income is required with the application.
If you ***Did Not and Do Not*** plan to file a Federal Income Tax return and ***Do Not*** receive Social Security, Disability or VA income, a ***Verification of Non-filing*** from the IRS is needed. To obtain the Verification of Non-filing from the IRS, please complete the 4506-T form attached and send it to the IRS at RAIVS Team, P.O. Box 9941, Mail Stop 6734, Ogden, UT 84409. The Verification Letter obtained from the IRS will need to be submitted as this part of your Financial Assistance Application supporting documentation.

The following types of accounts are ***not eligible*** for financial assistance discounts:
Any outside facility billing •Cosmetic surgery •Infertility services• Any account relating to a liability, motor vehicle accident, or crime that is in litigation or in review with another program •Gastric bypass or lap band surgery

Applicant Information Form 2020

Patient Name: _____ DOB_____ MR#_____

Patient Name: _____ DOB_____ MR#_____

Address: _____ Phone #_____ Cell #_____

_____

List dependent names:

_____ Relation: _____ Age: _____

_____ Relation: _____ Age: _____

_____ Relation: _____ Age: _____

Are you disabled? _____ Are you retired? _____ Do you currently have Medicare_____

Covered by Medicaid*? _____

Are you financially supported by another party?_____ List name and relation_____

***As part of the Financial Assistance Application process, each applicant must apply for Medicaid. Medicaid screenings may be completed by contacting your local Department of Social Services or by contacting the Carteret Health Care Advocatia Field Representative at (252) 499- 6570. If you currently have Medicaid, please submit a copy of your valid Medicaid card.**

If you do not file taxes, please complete the following :

Current Monthly Income: Current employment monthly income $_____

Disability (☐ yes ☐ no) $_____ Unemployment (☐ yes ☐ no) $_____

Social Security (☐ yes ☐ no) $_____ Child support (☐ yes ☐ no) $_____

VA income (☐ yes ☐ no) $_____ Retirement/Pension (☐ yes ☐ no) $_____

Rental income (☐ yes ☐ no) $_____ Stocks/ bonds (☐ yes ☐ no) $_____

GROSS MONTHLY INCOME (INCLUDE ALL AMOUNTS FROM ABOVE)

This includes yourself and spouse $_____ (Total Household Income)

Checking/Savings $ _____/ $ _____ Bank _____

I certify that the above financial information is true and correct to the best of my knowledge.

Patient Signature _____ Date _____

Spouse Signature _____ Date _____

2020 Supporting Documentation Worksheet

Please locate the number that best describes your means of income and provide all required documents listed. Please do not send originals of requested tax and financial information. Incomplete applications will not be accepted and will be returned by mail.

1. Patient that filed taxes
2020 Applicant Information Form
Complete Federal Income Tax Return and all supporting schedules
Letter of denial of Medicaid or copy of valid Medicaid card

2. Patient that did not file taxes
2020 Applicant Information Form
Signed/Notarized Statement of Non-Filing of Taxes
Verification of Non-Filing of Taxes from IRS
Proof of Income/Support of Supporting Party
Letter of denial of Medicaid or copy of valid Medicaid card

3. Patient that did not file taxes and collects Social Security
2020 Applicant Information Form
Signed/Notarized Statement of Non-Filing of Taxes
Proof of Income/Support
Letter of denial of Medicaid or copy of valid Medicaid card

4. Patient that did not file taxes and collects Social Security Disability
2020 Applicant Information Form
Signed/Notarized Statement of Non-Filing of Taxes
Proof of Income/Support

You will be notified by mail after the application process is complete advising you of your approval percentage. Your accounts ***will not*** be placed on hold during the financial assistance application process. To avoid referral to a collection agency until your application has been processed completely, please contact our office, (252) 499- 6506 to make a payment or set up payment arrangements.

For any questions regarding the Financial Assistance Application, please feel free to contact:
Whitney Chigas
Financial Assistance Program Coordinator
Phone: (252) 499-6517 Fax: (252) 808-6943 Email: wbchigas@carterethealth.org

Statement of Non-Filing of 2019 Taxes

If you ***did not*** and ***do not plan*** to file Federal Income Taxes for ***2019*** due to limited or no income, you must ***sign and*** have the statement below ***notarized***.

If you ***do not have any income*** to report or are being financially supported by another person, you must ***sign and*** have the statement below ***notarized***. Financial support includes shelter, food, living expenses, etc. You will need to provide proof of income of supporting party with your application.

This letter ***must be signed by you and the person supporting you in front of a notary***. If this supporting party claims you on their tax return, please submit a copy of their 2019 Federal Tax Return with your complete application.

I, _____ do hereby swear that on this _____ day of _____, 2020.

I ***Did Not*** and ***Do Not Plan*** to file Federal Income Taxes for the year ***2019*** due to limited or no income. I am being financially supported by: Self_____ Spouse_____ Parent_____ Other (please specify) _____

This is for the purpose of receiving financial assistance at Carteret Health Care.

_____ _____

Applicant Signature Date

_____ _____ _____

Person Financially Supporting Applicant Relationship to Applicant Date

I, _____, a Notary Public for _____ County, North Carolina, do hereby certify that _____ personally appeared before me and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal, this the _____ day of _____, 2020.

_____ _____

Notary Date

My Commission Expires: _____

Carteret HEALTH CARE

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CARTERETHEALTH.ORG