NOVANT HEALTH

For Office Use Only
Patient Type _____
Amount of W/O $_____
S/A Results: _____h/h $ _____
Facility _____
Account #_____
Med. Rec.#

I. Patient Demographics

Patient Name: _____
(Last) (First) (Middle)

_____
(SSN) (DOB)

Guarantor Name: _____
(Last) (First) (Middle) (SSN) (DOB)

Address: _____
(Street) (City) (State) (Zip Code)

_____
(Phone)

Have you applied for Financial Assistance with any Novant Health, Inc. facility (e.g. Novant Medical Group, Presbyterian Hospital, Brunswick Community Hospital, Thomasville Medical Center, Forsyth Medical Center, etc.) in the past?_____ Yes _____ No.
If yes, date of application or approval? _____

II. Household Information

Marital Status (Circle One)	Married	Single	Separated	Total in Household

Dependent Name(s)	Dependent Date of Birth

III. Employment/Income

Patient/Guarantor Employer:
Gross Monthly Income Amount $
Income Source-*Please attach verification or explanation of current situation*
Spouse or other Income Source and Gross Monthly Amount $
Total Annual Gross Household Income $
If no income, how do you support yourself?

Do you have an active bank account?	Did you file taxes for the prior year?

IV. Insurance Verification

Does your employer offer health insurance	YES	NO
Do you have any health insurance	YES	NO
Name of Insurance Company:		
Are you employed?	YES	NO

If you have become unemployed within the last 90 days, please provide:

The name of your last employer and dates of employment:

Give the name of your employer sponsored insurance carrier:

Are you eligible for COBRA Benefits?

I certify that the information provided is true and to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I authorize the release of any information needed to verify the information provided and for billing and collections in compliance with applicable federal and state laws. Proof of income may be required before any consideration is made. Acceptable proof of income maybe but not limited to: copy of paycheck stubs, copy of last year's tax return, or letter from employer stating present salary and hours worked.

Signature Patient/Guarantor:	*Date:*
% Federal Poverty Level:	Decision Based On:
Comments/Summary:	

Signature of Interviewer		Date:		
Signature of Manager		Date:	Approved	Denied
Signature of Director		Date:	Approved	Denied
Signature of EVP/VP		Date:	Approved	Denied

Mail Completed Application to: Novant Health, ATTN: Financial Assistance, PO BOX 11549, Winston Salem, NC 27116

Notice of nondiscrimination

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  - Information written in other languages

If you need these services, please contact Novant Health interpreter services toll-free at 1-855-526-4411, then select option 3. TDD/TTY: 1-800-735-8262.

If you believe that Novant Health has not provided these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Patient services department
Attn: Section 1557 coordinator
200 Hawthorne Lane
Charlotte, NC 28204

Telephone: 1-888-648-7999 (toll-free)
TDD/TTY: 1-800-735-8262
NovantHealth.org/home/contact-us.aspx

You may file a grievance by mail, in person at the Novant Health facility where care was provided, or by submitting the form at the link above. If you need help filing a grievance, call toll-free, 1-888-648-7999 or TDD/TTY 1-800-735-8262.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available online at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **hhs.gov/ocr/office/file/index.html**

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Français (French)	*IMPORTANT : Des services d'assistance linguistique gratuits sont à votre disposition. Appelez le +1 855 526 4411. Sélectionnez l'option 3. Dispositif de télécommunication pour sourds et malentendants : +1 800 735 8262.*
العربية (Arabic)	*ملاحظة: خدمات المساعدة اللغوية المجانية متاحة لك. اتصل على الرقم 1-855-526-4411. اختر الخيار 3. جهاز الاتصال الكتابي/الهاتف النصي: 1-800-735-8262.*
Русский (Russian)	*ВНИМАНИЕ: Для вас доступна бесплатная услуга языковой поддержки. Позвоните по телефону 1-855-526-4411. Выберите вариант 3. Текстовый телефон/телетайп: 1-800-735-8262.*
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አማርኛ (Amharic)	*ማሳሰቢያ፦ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ 1-855-526-4411 ላይ ይደውሉ። አማራጭ 3 ን ይምረጡ። TDD/TTY፦ 1-800-735-8262.*
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ગુજરાતી (Gujarati)	*સાવધાન: તમારા માટે ભાષા સહાય સેવાઓ, વિના મૂલ્યે, ઉપલબ્ધ છે. 1-855-526-4411 પર કૉલ કરો. વિકલ્પ 3 પસંદ કરો. TDD/TTY: 1-800-735-8262.*
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Attn: Section 1557 coordinator
200 Hawthorne Lane
Charlotte, NC 28204

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