Ashe Memorial Hospital

Ashe Memorial Hospital (AMH) has a financial assistance program for patients who cannot afford to pay for medical care received at AMH. Eligibility for this program is generally based on your family's income, size, and assets. It may also be based on whether your medical expenses would constitute a medical hardship.

This application applies only to care received at Ashe Memorial Hospital, Inc., and does not apply to services rendered at Mount Jefferson Family Medicine, Mountain Family Care Center, Ashe Oncology, Ashe Orthopedics, or any independent providers who provide care in the hospital including but not limited to Emergency Physicians, Anesthesiologists, and Radiologists. Please refer to our Charity Care policy on our website www.ashememorial.org or by contacting a Financial Counselor at the phone number and/or address listed below.

In order to be considered for the hospital's financial assistance program, please complete the attached application form. You must also include supporting documentation as applicable; please see the list below.

- If employed within the last 12 months, include a copy of:
  - The last 3 recent payroll check stubs from each company. (Please indicate whether paid weekly or bi-weekly.)
  - Income tax return for the last year.
  - W-2 tax statement(s)
- If unemployed and receiving unemployment compensation benefits, please include a copy of the benefit notification, and date benefits started.
- If you have been unemployed or had a significantly low income for the past year, we require a written statement from the person or persons supporting you.
- Copy of your Social Security check or bank statement if you receive direct deposit.
- Your Workers' Compensation notification letter.
- A copy of child support income.
- If self-employed: complete documentation of revenue and business related expenses per month for the last 12 months and a copy of tax filing, including all Schedules or other schedules showing gross receipts.
- A Copy of the last 3 months of your checking and/or savings bank statements and statements for all CD's and other investments such as stocks, bonds, IRA's, etc.
- A copy of your most current County Tax notice (if you are a homeowner) for all properties.
- Copy of current month Home Mortgage Statement(s).

If you have any questions or need assistance in completing the application, please contact a Financial Counselor at (336)846-0725. If you cannot complete the form, you may have an authorized representative fill it out for you.

Please keep a copy of this application and mail the original completed application and supporting documentation to the address below:

Ashe Memorial Hospital
Attn: Financial Counselor
200 Hospital Avenue
Jefferson, NC 28640-9244

Ashe Memorial Hospital

CONFIDENTIAL FINANCIAL STATEMENT – REQUEST FOR FINANCIAL ASSISTANCE

Patient Name: _____ Date of Birth: _____ Application Date: _____

Account number: _____ Last 4 of Social Security #:_____ Marital Status: _____

RESPONSIBLE PARTY

Name: _____ Marital Status: _____ Home Phone: _____

Address, City, State, Zip: _____

Employer's Name and Address: _____

Business phone: _____ Position/Title: _____ Length of Employment: _____

SPOUSE

Name: _____ Marital Status: _____ Home Phone: _____

Address, City, State, Zip: _____

Employer's Name and Address: _____

Business phone: _____ Position/Title: _____ Length of Employment: _____

OTHERS IN HOUSEHOLD

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAID STATEMENT

Please check the appropriate statement circles. Attach copies of DSS notice including attachments.

1. I/We ⬭ **have** ⬭ **have** not applied for Medicaid to cover these services.
If not, please explain reason:

2. I/We ⬭ **have** ⬭ **have not** been rejected by Medicaid.
Reason for rejection (include copy):

3. I/We received an approval from Medicaid, but with a monthly spend down of $_____.

MONTHLY HOUSEHOLD INCOME

Attach verification of all types of income	Person 1	Person 2	Person 3
Name			
Gross Monthly Income			
Unemployment/Workers Comp Benefits			
Child Support/Alimony			
Social Security			
Dividends/Interest			
Investments/Rental Income			
Governmental Assistance/Food Stamps			
Other Income			

ASSETS

Checking Balance _____ Savings Balance _____

Number of operating vehicles you own (cars, trucks, boats, off-road vehicles, etc.) _____

Make	Model	Year	Value

EXPENSES PER MONTH

*** You will be required to provide receipts for proof of expenditures.**

Mortgage/Rent		Clothes	
Gas/Heat		Telephone/Cell	
Electricity		Child Care	
Water/Sewage		Food	
Cable/Satellite		Medical Bills	
Vehicle Payments		Medicine	
Transportation/Fuel		Other (Specify)	
Insurance(s)		Other (Specify)	

Other comments you would like to make regarding your financial situation:

We may require additional documentation in order to assist you. If so, we will contact you at the telephone numbers you have listed. Patients who fail to follow through in the application process or who refuse to apply for outside programs and who potentially may have qualified may be denied financial assistance.

I hereby state that the information given herein is true and complete. I authorize any required verification, including credit bureau reports. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance does not pertain to other healthcare providers.

Signature of applicant Date

Signature of co-applicant Date

For Internal Use Only:

Total Gross Income per Month _____

Total Net Income per Month _____

Total Expenses per Month _____

Surplus Income per Month _____

_____ Approved _____% write-off _____ Denied

Comments: _____

Authorized AMH Staff Signature Date