Onslow Memorial Hospital
Where People Care

Administrative Building
241 New River Dr.
Jacksonville, NC 28540
910-577-4703 Option 3

Application for Patient Assistance Program

Patient's Name: _____ DOB:_____

Address: _____ Phone Number: _____ Total Family Size:

Name	DOB	Relationship	Income

I certify that the above information is true and accurate to the best of my knowledge. I will apply for financial assistance from other parties (Medicaid, Medicare, ect) that may cover the cost of my healthcare and I agree to assign or pay to the hospital/clinic any covered benefits to which I am entitled.

I understand that this application will be used by the hospital/clinic to determine my eligibility for the Patient Assistance Program using criteria established by and kept on file in the hospital/clinic. I understand that providing untrue/inaccurate information will result in being disenrolled from the clinic and that the hospital may take additional actions if deems appropriate.

Date: _____ Signature:_____

For Internal Use Only

Date Delivered to Provider:_____ Received By:_____

Household Salary: _____ Other Household Income: _____ Total Household Income:_____

Acct. Number	Date	Amount Owed	Acct. Number	Date	Amount Owed

On _____ I notified the above name patient that:

- ☐ He/She was eligible for the Patient Assistance Program – 100%
- ☐ He/She was not eligible for the Patient Assistance Program
- ☐ A determination as to eligibility will be delayed _____
- ☐ A determination as to eligibility has been denied. The required information has not been received within 30 days.

Date:_____ Signature: _____ Title: Credit Coordinator