



Application for Patient Assistance Program

Patient Financial Services
200 Memorial Drive
Jacksonville, NC 28546
910-577-4703

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: _____