FINANCIAL HARDSHIP APPLICATION

BOICE-WILLIS CLINIC

Patient Information…

Patient Name: _____ BWC Account #: _____

Date of Birth: _____ Driver License # *or* Adult ID #: _____

Home Phone: _____ Cell Phone: _____

Address: _____

No. of members living in the household: _____

Responsible Party Name: _____

Responsible Party Relationship to Patient: _____

Employer Name: _____

Employer Address: _____

If unemployed, how long? _____

Medical Insurance Coverage: _____

Spouse Information…

Spouse Name: _____ Date of Birth: _____

Driver License # *or* Adult ID #: _____

Address: _____

Employer Name: _____

Employer Address: _____

If unemployed, how long? _____

Medical Insurance Coverage: _____

Monthly Family Income & Source

	Patient	Spouse	Responsible Party	Children Working
Monthly Salary (Gross)				
Public Assistance Benefits				
Unemployment Benefits				
Social Security Benefits				
Work's Compensation				
Other (Alimony, etc.)				

Total Monthly Household Expenses: $_____

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No Income comment section:

_____

_____

_____

_____

_____

_____

I ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AM UNABLE TO PAY FOR MEDICAL EXPENSES NOT REIMBURSED BY MEDICAL INSURANCE DUE TO FINANCIAL HARDSHIP. I CERTIFY THAT NO OTHER SOURCE IS LEGALLY RESPONSIBLE FOR MY BILLS.

Would you like your original documents mailed back to you? _____

_____	_____	_____
*Responsible Party Name **(Print)***	*Responsible Party Signature*	*Date*
_____	_____	_____
*Spouse Name **(Print)***	*Spouse Signature*	*Date*

********** DO NOT WRITE BELOW THIS SECTION **********

BOICE-WILLIS CLINIC OFFICE USE ONLY

BWC PERSONNEL: ALL INFORMATION BELOW IS REQUIRED.

Patient's MRN: _____

This application was received on the _____ of _____, _____.
Day *Month* *Year*

Received by: _____, _____.
Personnel Name *Job Title*

Approved by Central Business Operations: _____ _____
Signature *Date*

FINANCIAL HARDSHIP REQUIRED INFORMATION GUIDE

BOICE-WILLIS CLINIC

The following information listed under Income Verification and Additional Verification is required on the behalf of the applicant. Any information withheld or falsified on the application will result in a prolonged reviewing process and/or automatic dismissal of the application.

Income Verification…

- ☐ Most **Recent** IRS Tax Forms (1040 and/or W-2) *(This form must be Signed)*
- ☐ Paycheck Stubs for the **past 30-Days** for **all** persons employed in the home
- ☐ Verification of **any other** income received (i.e. child support, social security, alimony)
- ☐ Unemployment Paycheck Stubs for **past 30-Days**
- ☐ **Past 3 months** of Bank Statements

OR

- ☐ **If you have no income,** please provide a letter or comment on page 2 stating your source of income in order to pay for living expenses.

Additional Verification…

- ☐ Driver's License or Identification Card for Adults
- ☐ Proof of Outstanding Bills (payment stubs, cancelled checks, etc.)
- ☐ Letter of Denial from DSHS or Medicaid Form/Card

PLEASE BE SURE TO FULLY COMPLETE THE APPLICATION AND SIGN

Please return the application and all required information to your Physician's Office or by mail:

Boice-Willis Clinic
P.O. Box 7200
Rocky Mount, NC 27804

*If you have question regarding the completion of this application, contact the BWC Business Office at **(252) 937-0360**.