CHESAPEAKE REGIONAL HEALTHCARE

FINANCIAL ASSISTANCE APPLICATION

Applicants must submit all required documents in the same mailing or fax to: **Chesapeake Regional Healthcare, Attn: Financial Counselor, 736 Battlefield Blvd., North, Chesapeake, VA 23320** | Fax #: **757-312-6591**.

Patient Name:	Date of Birth:	Account #
Address:	Social Security #:	Phone #:
Marital Status:	Employer:	Spouses employer:

Check the box if the patient is a minor ❑

Unemployment Verification: *I attest that I have been unemployed since _____ and my last employer was_____.*

FAMILY MEMBERS: List spouse or dependents as listed on tax return.

Name	Age	Relationship

PLEASE CHECK IF YOU RECEIVE OR CURRENTLY HAVE THE FOLLOWING RESOURCES:

❑ SNAP ❑ FOOD STAMPS ❑ GOVERNMENT INCOME HOUSING ❑ GAP MEDICAID ❑ PLAN FIRST

Please answer the following questions below and provide the required documents:

Please answer all questions listed below			**If YES,** please provide the following documents for **EACH** member of the household
Do you have health insurance?	❑ Yes	❑ No	**UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE.**
If no, Have you attempted to apply for Medicaid in the last 6 months and been denied? (Please provide validation letter)	❑ Yes	❑ No	
Is any member of your household **employed**?	❑ Yes	❑ No	3 current pay stubs **or** tax return from the most recent tax year
Is any member of your household **self-employed**?	❑ Yes	❑ No	Complete tax return packet from the most recent tax year
Is any member of your household receiving **unemployment benefits**?	❑ Yes	❑ No	Benefit letter or Unemployment printout from State website
Is any member of your household receiving **social security**?	❑ Yes	❑ No	Social Security benefit letter
Is any memeber of your household covered by Medicare?	❑ Yes	❑ No	Provide CRH Medicare expense sheet
Does any member of your household receive **alimony or child support**?	❑ Yes	❑ No	Court order document
Does any member of your household have a **checking, savings, or money market account**?	❑ Yes	❑ No	Attach **complete** copy of current 30 day statement for **each** account
Does any member of your household have **any other source of income**?	❑ Yes	❑ No	GI bill, dividend, rental property, etc. Attach current statement(s)

I certify the above information is correct and true. I authorize Chesapeake Regional Healthcare to verify this information with employers and other agencies. I understand this information is subject to review by federal and/or state agencies. I understand I must provide required documents in order to complete this application. Incomplete applications will be denied.

*****PLEASE NOTE APPLICATION WILL NOT BE CONSIDERED ON ACCOUNTS THAT ARE WITH A COLLECTION AGENCY. *****

Signature: _____ **Date:** _____

*It is the patient's responsibility to confirm we received your application and documents. Please call **757-312-6281**.*