Harnett Health

Hospital Sponsored Financial Assistance Application

FAP is a financial assistance program for patients who receive services at Cape Fear Valley Health. Eligibility is based on family size and household income as compared to the federal poverty guidelines.

Please fill out all information completely to prevent any delays in processing your application.

Patient Information-REQUIRED			
Patient Name	Last 4 of Social Security #	Date of Birth	Account #
		Home Phone #	Mobile Phone #

Guarantor Information-REQUIRED				
Guarantor Name	Relationship to Patient	Social Security #	Date of Birth	Marital Status
Address		City, State and Zip		
Employer	Hours Per Week	Hourly Pay	Work Phone#	
Spouses Employer	Hours Per Week	Hourly Pay	Work Phone#	

Note: If the address where you receive mail is different from the address where you live, please fill out the "mailing address" information below

Mailing Address	City, State and Zip

Health Insurance Information ☐ Check this box if the patient does not have any source of health coverage				
Health Insurance	Subscriber	Policy #	Group #	Effective Date
Has a member of the household lost their job within the last 60 days?			Yes	No
Did he/she receive a COBRA election notice?			Yes	No
Did he/she elect COBRA coverage?			Yes	No
If he/she did not elect COBRA coverage, why?				
Has he/she applied for Medicaid?			Yes	No

Please List All Household Members Below-REQUIRED			
Name	Age	Last 4 of Social Security #	Relationship to Patient

Monthly Household Income		
Type of Income	Guarantor Monthly Gross Income	Spouse's Monthly Gross Income
Regular Wages	$	$
Retirement/Pension/Social Security	$	$
Disability	$	$
Unemployement	$	$
Child Support/ Alimony	$	$

Worker's Compensation	$	$
Other:	$	$

Supporting Documentation-REQUIRED				
Document Type	Guarantor		Spouses	
	Provided	Not-Provided	Provided	Not-Provided
Current Bank Statement	☐	☐	☐	☐
Last Two Pays Stubs	☐	☐	☐	☐
Proof of Any Other Income Listed Above (if direct deposit bank statement can be used)	☐	☐	☐	☐
Copy of most recent tax return	☐	☐	☐	☐
Disability Statement-If Applied or Receiving Disability	☐	☐	☐	☐
Unemployment Statement-If Applied or Receiving Unemployement	☐	☐	☐	☐
Social Security Statement - If receiving Social Security	☐	☐	☐	☐
Self Employed - Tax Return	☐	☐	☐	☐
Patient is Deceased - Death Certificate and Estate Info if Applicable	☐	☐	☐	☐

** Applications will not be processed if all information is not provided*

Statement of Support
I certify that I have been unemployed for the last _____ years/_____ months. As a result of being unemployed, I receive food, shelter and clothes from _____ (relationship to applicant)_____

Acknowledgement of Signatures-REQUIRED	
I hereby certify that the information provided in the application is true, accurate and complete to the best of my knowledge. I hereby authorize the hospital to contact any person, firm or organization to verify any of the information given and I hereby authorize any such person, firm or organization to release to the hospital any financial information it may request. I am aware that any guarantor payments made on accounts where financial assistance is applied will not be refunded.	
Applicant Signature	Date

To be used by Patient Financial Services Department Only

Date Received:		
Income Verified: Y/N		
Application Amount:		
Application Status: Approved/Denied	If Denied, why?	
Amount Adjusted to FA:	Amount due from Responsible Party:	
Authorizing party sign and date:		