

Patient Financial Assistance Application

Westcare Health System
Attention: Patient Financial Services
68 Hospital Road Sylva, NC 28779

Please return the application with supporting documentation to the address listed above within 30 days of receipt. Applications require your last income tax return and a current paycheck stub with year-to-date totals. Incomplete applications or missing documentation will delay the approval process.

Patient Name: _____ DOB: _____
Social Security Number: _____ County of Residence: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Physical Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Immediate Family Members Living in the Home:

Name: _____	DOB: _____	Relationship: _____	SSN: _____
Name: _____	DOB: _____	Relationship: _____	SSN: _____
Name: _____	DOB: _____	Relationship: _____	SSN: _____
Name: _____	DOB: _____	Relationship: _____	SSN: _____
Name: _____	DOB: _____	Relationship: _____	SSN: _____
Name: _____	DOB: _____	Relationship: _____	SSN: _____

Employment Info for Patient or Responsible Party:

Employer: _____	How long at current Employer: _____
Employee: _____	Relation to Patient: _____
Hourly Wage: _____	Hours per Week: _____
Date Last Worked: _____	Income while out of work: _____
(if currently unemployed)	

2 nd Employer: _____	How long at current Employer: _____
Employee: _____	Relation to Patient: _____
Hourly Wage: _____	Hours per Week: _____
Date Last Worked: _____	Income while out of work: _____

Employment Info for Spouse

Employer: _____	How long at current Employer: _____
Employee: _____	Relation to Patient: _____
Hourly Wage: _____	Hours per Week: _____
Date Last Worked: _____	Income while out of work: _____
(if currently unemployed)	

2 nd Employer: _____	How long at current Employer: _____
Employee: _____	Relation to Patient: _____
Hourly Wage: _____	Hours per Week: _____
Date Last Worked: _____	Income while out of work: _____

Other Income - Circle type (Social Security, Disability, Pension, VA, Child Support, Rental Income, Disbursements)

Rcvd by: _____ Amount: \$ _____ Date Rcvd: _____ Date Begun: _____
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Assets

Savings Account:

Owners Name: _____ Bank: _____ Balance: _____

Stocks/Bonds/IRA/CD'S/Trust Fund:

Owners Name: _____ Type: _____ Balance: _____

Owners Name: _____ Type: _____ Balance: _____

Real Estate:

Primary Residence: Own Rent Mortgage State: _____ County: _____

Additional Homes: Own Rent Mortgage State: _____ County: _____

Other Real Estate: Own Rent Mortgage State: _____ County: _____

Motor Vehicles

Name on Title: _____ Year/Make/Model: _____

Name on Title: _____ Year/Make/Model: _____

Name on Title: _____ Year/Make/Model: _____

Name on Title: _____ Year/Make/Model: _____

Other Property: (Boats, Campers, Trailers, etc.)

Owner: _____ Description: _____

Owner: _____ Description: _____

Are any of the accounts listed due to any type of auto or personal injury accident? _____

If yes, please provide description of injury, liability insurance information or attorney representation:

Liability Insurance Carrier: _____ Insured: _____

Claim Number: _____ Adjuster: _____

I certify that the above application is true and accurate to the best of my knowledge. Furthermore, I agree to go through the hospitals screening process for insurance (Medicaid, Medicare, or other identified sources of assistance which may be available to pay my hospital charges. I will take any action reasonably necessary to obtain such assistance. Additionally, any amounts recovered for hospital charges will be assigned or paid to the hospital. If any information I have given proves to be untrue, I understand that I may no longer be eligible for any uncompensated services and will be fully responsible for any unpaid charges.

Signature: _____

Date: _____