WILMINGTON HEALTH
AMBULATORY SURGERY CENTER

Dear Patient,

Thank you for choosing Wilmington Health Ambulatory Surgery Center ("WH ASC") to meet your health care needs. Our financial assistance program relieves the financial burden of medically necessary health care and is available to patients and families with a household income at or below 250% of the Federal Poverty Guideline for your family size.

To determine your eligibility, please complete the enclosed application and provide **all** required supporting documents. Return the application and the supporting documents in the envelope provided, upload on WH ASC's website, or submit by secure fax to (910)523-5031. **Failure to return a complete application with all supporting documents will delay your application decision and normal billing procedures will continue.**

Required Documents

Income and Assets	Proof of most recent **30 days** gross income and assets for the patient, spouse or guarantor, and all household dependents 18 years of age and older as listed on the income page of the application. **Household gross income and assets includes but are not limited to** pay wages, self-employment, social security, Veterans benefits, pension, investments, retirement, unemployment, workers' compensation, alimony, disability, rental properties, and bank accounts. **If you do not have any income, please include a letter of support, signed and dated, from the person who provides you with assistance.**
Tax Return	A copy of the most recent year Federal Tax Return – Form 1040 including **all** schedules. If you do not have a copy of your taxes **call the IRS at 1-800-829-1040 for a free transcript.**
Bank Accounts	Most recent month traditional and/or alternative bank account statements for checking, savings, money market, investment, and/or retirement accounts. Must be in bank statement format showing beginning balance, transactions, and ending balance. Include **all** pages of the statement with the last four digits of the account number visible.
Property	Tax value of owned property other than your primary residence. If other property is a rental property, provide proof of rental income such as a lease agreement or receipt.
Other	If no taxes filed provide birth certificates or custodian documents for all minor dependents, marriage certificate if married, death certificate if patient is deceased.
	Do NOT send original documents.

If you are eligible for NC Medicaid or other State or Federal programs, you must apply and continue to pursue all benefits. To complete the required screening for Medicaid, contact your local Department of Social Services.

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WH ASC Financial Assistance Application

Submit via WH ASC's website at https://www.wilmingtonhealth.com/specialties/ambulatory-surgery-center/ or secure fax: (910)523-5031

For questions or assistance, call (910)815-3205

I: NC Medicaid Eligibility Requirement

If you do not have health insurance and have not applied for NC Medicaid in the past 12 months, **contact your local county Department of Social Services for eligibility screening.**

Have you applied for NC Medicaid in the last 12 months?	**If yes**, what was the outcome?
☐ Yes ☐ No	☐ Approved ☐ Denied ☐ Pending ☐ Not Eligible

II: Patient Information

Name (Last, First, Middle Initial)	Birth Date (mm/dd/yyyy)	Guarantor No. or Medical Record No.	
Address	City	State	ZIP Code

Phone Number	Email Address (optional)	Marital Status
		☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Minor

Employment Status	Employer Name	Employer Phone Number
☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Minor		
Procedure Description	Physician	Proposed Date of Service

III: Spouse or Guarantor (if patient is a minor under 18 years old)

Name (Last, First, Middle Initial)	Birth Date (mm/dd/yyyy)	Phone Number

Employment Status	Employer Name	Employer Phone Number
☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student		

IV: Household Dependents

Full Name	Relationship	Date of Birth	Medical Record No.
1.			
2.			
3.			
4.			

V: Family Gross Income and Assets

Most recent **30 days** of income for the patient, spouse or guarantor, and all household dependents 18 years of age and older. **Please send proof of monthly income by providing:** pay wages, award letters, tax returns, letter from the employer, profit and loss statements for self-employment, complete statements, and benefits letters. ***Do NOT send originals.***

If you do not have any income, please include a letter of support, signed and dated, from the person who provides you with assistance.

Banking: Do you have a bank account? ☐ **YES** ☐ **NO** Bank Name(s):

Type of account you and/or your spouse have: ☐ Checking ☐ Savings ☐ Investments ☐ Retirement

Include most recent statement(s) for all accounts (all pages). Last 4 digits of the account number must be visible.

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Property: Do you own Real Estate OTHER than your primary residence? □ **YES*** □ **NO** ***If yes, include property Tax document. If a rental property, provide proof of rental income.**
Taxes: Do you file taxes? □ **YES*** □ **NO** ***If yes, include the most recent Federal Tax Return including all schedules.**

VI: Advocate (Optional)

If you have an advocate who is assisting you with the application process, please include the name and phone number. By providing the advocates contact information you give us permission to speak to the advocate on your behalf.

Name of Advocate:_____Phone:_____

Additional Comments:

VII: Signature and Date Required

I certify that all information listed is true to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I give permission for WH ASC and its affiliate Wilmington Health to verify the information provided on this application.

Patient Signature	**Sign Date (mm/dd/yyyy)**
Guarantor Signature (if patient is a minor under 18 years old)	**Sign Date (mm/dd/yyyy)**