



Chesapeake Regional Healthcare Financial Assistance Application

Applicants must submit all required documents in the same mailing or fax to:

Fax #: (757) 312-6591 Mailing Address: ATTN: Financial Counselor 736 Battlefield Boulevard, North Chesapeake, VA 23320.

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

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? <input type="checkbox"/> Y <input type="checkbox"/> N If no, Have you attempted to apply for Medicaid in the last 6 months and been denied? <input type="checkbox"/> Y <input type="checkbox"/> N (Please provide validation letter)	UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE.
Is any member of your household employed ? <input type="checkbox"/> Y <input type="checkbox"/> N	3 current pay stubs or tax return from the most recent tax year.
Is any member of your household self-employed ? <input type="checkbox"/> Y <input type="checkbox"/> N	Complete tax return packet from the most recent tax year.
Is any member of your household receiving unemployment benefits ? <input type="checkbox"/> Y <input type="checkbox"/> N	Benefit letter or Unemployment printout from State website.
Is any member of your household receiving social security ? <input type="checkbox"/> Y <input type="checkbox"/> N	Social Security benefit letter
Does any member of your household have a Retirement or Pension (401K, IRA, 403b) <input type="checkbox"/> Y <input type="checkbox"/> N	Pension/Retirement benefit letter or statement of current balance.
Does any member of your household receive child support ? <input type="checkbox"/> Y <input type="checkbox"/> N	Court order document.
Does any member of your household have a checking, savings, or money market account ? <input type="checkbox"/> Y <input type="checkbox"/> N	Attach <u>complete</u> copy of current 30 day statement for <u>each</u> account.
Does any member of your household have any other source of income ? <input type="checkbox"/> Y <input type="checkbox"/> N	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. (757)312-6281