Centra
Application For Financial Assistance
CONFIDENTIAL

Dear Valued Patient:

If you are in need, Centra wants to help you with understanding your bill. For those who may not have health insurance or other ways to pay for their care, we offer several options for assistance. Because we promise to care for our community, our programs provide assistance for those who meet certain financial levels.

Patients who have income at or below 133% of the federal poverty level may qualify for full assistance. Patients with income between 200% and 400% may qualify for discounts based on the amount owed.

If you have questions call 434-200-3777 to speak with a customer service staff member. You may also complete Centra's Financial Application and mail it to the business office.

STEP 1: Complete patient information. Please fill out all information concerning the patient completely.
STEP 2: Fill out income and asset information. This includes income from your employer, social service aid (food stamps, ADC), government aid (social security, VA benefits), and all other income. If any child is 18 years or older, a separate form is required.
STEP 3: Fill out monthly expenses. This includes mortgage payment, rent, utilities, loans, medical, or other expenses.

Please determine which types of documentation below may apply to your situation: (Send copies only. Originals will not be returned).

- **PAY CHECK STUBS:** If you are employed, you must provide one month's worth of your pay check stubs, not more than three months old. If your stubs are not available, you need to provide a letter from your employer stating one month's salary.
- **UNEMPLOYMENT:** Forms verifying weekly benefits.
- **SELF EMPLOYED:** Provide your current year Federal Income Tax return, including all schedules.
- **OTHER RESOURCES:** Retirement benefits, General Relief check, ADC check, trust fund allotments, child support check and alimony.
- **GOVERNMENT BENEFITS:** Letter confirming or denying Social Security, SSI, VA or other government benefits, copy of check(s) or bank statement showing automatic deposit.
- **SOCIAL SERVICES:** Approval, denial, or pending status from your local department of social services. Any letters confirming receipt of housing and/or food stamps monthly benefit amount.
- **BANK STATEMENTS:** Most recent savings and/or checking account statement(s) from the bank or credit union.
- **SICK LEAVE:** Statement from doctor stating dates you are unable to work. Statement from employer indicating paid sick leave or if you are on leave without pay, year to date gross and hire date.
- **LETTER OF SUPPORT:** Letter verifying support from family or friends (when no income is reported or not enough to show support)
- **STUDENTS:** Scholarship, loan, workstudy, stipend, tuition, or grant award amounts.

STEP 1: COMPLETE INFORMATION BELOW:

Patient Name:	Soc Sec #:	
Address:	Birth Date:	
City, State, Zip:	Phone #:	Medical Record #:

STEP 2: FILL OUT INCOME / ASSET INFORMATION *If there is no reported income, explain your means of financial support.

Who is head of household? *This is the member of the family who provides food and shelter for the applicant. The applicant may be the head of the household. A nonfamily member should not be listed in the family section.*

Family Members - include self and claimed dependents in household	Age	Relation to head of household	Gross monthly income (pretax)	Employer Name	Employer Phone #

If patient or head of household is unemployed, please provide the date employment was terminated:________________________

Patient Label

PLEASE MAIL COMPLETED FORM TO:
Attention: Customer Service
Centra Patient Accounting Services
PO Box 2496
Lynchburg, Virginia 24505-2496

Centra
Application For Financial Assistance

STEP 2: INCOME / ASSETS, CONTINUED

Do you have Medicaid? Yes / No *If yes, please provide a copy of your Medicaid card.

Have you ever applied for Medicaid? Yes / No *If yes, please list where and when:_______________________________________

Checking Acct? circle: Yes / No Acct Number:	Bank Name: Location:	Balance: $
Savings Acct ? circle: Yes / No Acct Number:	**Bank Name: Location:**	**Balance: $**
Investments? circle: Yes / No *Stocks, Bonds, IRA's, 401K / 403B, CD's etc.*	**Bank Name: Location:**	**Balance: $**

Real Estate Property? circle: Yes / No Address:	Rent / Buy *circle one*	Total acreage:	Monthly Payment: $
Real Estate Property? circle: Yes / No Address:	**Rent / Buy** *circle one*	**Total acreage:**	**Monthly Payment: $**

Taxable personal property: (circle one) Yes / No (list cars, boats, trucks, motorcycles, campers, mobile homes, etc.)

Item:	Make Model:	Year:	Amount Owed: $	Value: $
Item:	**Make Model:**	**Year:**	**Amount Owed: $**	**Value: $**
Item:	**Make Model:**	**Year:**	**Amount Owed: $**	**Value: $**

Do you have a life insurance policy for you or any dependent over 21 with a cash-in value over $1,500 (circle one)? Yes / No

Name of ins. co:_______________________________________ **Policy #:**_____________________ **Cash-in value? $**________________

Are you currently working with an attorney or insurance carrier on an accident claim (circle one)? Yes / No

____

Name of Attorney or insurance company Telephone Number Date of Accident / Claim Number

STEP 3: FILL OUT EXPENSES & LIABILITIES INFORMATION

Mortage / Rent	$	Electrical	$
Transportation (loan / gas amt)	$	**Other utilities:** (telephone, cable, water, etc)	$
Food	$	**Medical** (include prescription)	$
Loans	$	**Credit Cards** (total)	$
Other expenses	$		$
		Total Monthly Expense, all columns	$

IN ORDER FOR CENTRA TO COMPLY WITH STATE GUIDELINES, EACH OF THE ITEMS YOU HAVE LISTED ON THIS APPLICATION WILL REQUIRE DOCUMENTATION. PLEASE DO NOT SEND IN YOUR APPLICATION UNLESS YOU HAVE ATTACHED ALL NEEDED ITEMS. RETURN INFORMATION PROMPTLY OR YOU WILL BE RESPONSIBLE FOR YOUR FULL CHARGES.

THE INFORMATION PROVIDED IS TO THE BEST OF MY KNOWLEDGE COMPLETE, ACCURATE AND TRUE. I AUTHORIZE THE RELEASE OF ALL INFORMATION NEEDED TO DETERMINE WHETHER I QUALIFY FOR FINANCIAL ASSISTANCE THROUGH CENTRA'S FINANCIAL AID PROGRAM OR OTHER FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, INCLUDING VERIFICATION OF MY SALARY OR WAGES, THE BALANCE OF ANY BANK ACCOUNTS THAT I MAINTAIN, THE CASH-IN VALUE OF ANY LIFE INSURANCE POLICY, STOCKS, OR BONDS WHICH I POSSESS, AS WELL AS THE VALUE OF ANY REAL OR PERSONAL PROPERTY WHICH I OWN OR AM PURCHASING. SHOULD I BE REFERRED TO A FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, I AUTHORIZE CENTRA TO RELEASE AND OBTAIN ALL INFORMATION NEEDED TO DETERMINE ELIGIBILITY FOR THAT FUNDING.

***SIGNATURE(S) REQUIRED**

Applicant's signature:	Date / Time:
Spouse's signature:	**Date / Time:**

Patient Label