

# Financial Assistance Summary

Wake Forest Baptist Health recognizes the financial burden medical bills may cause for medically necessary services. Wake Forest Baptist Health provides financial assistance to patients who live within Wake Forest Baptist Health's service area. Determination of financial assistance is based upon a patient or legally responsible individual's household size, income and assets.

▶ **Who qualifies for a discount?**

Any patient or other person who is legally responsible for a patient's medical bills, residing in the 19-county service area, regardless of age, gender and nationality.

▶ **What services are covered?**

Any hospital inpatient, outpatient or emergency care ordered and provided by a physician.

▶ **How do I apply for financial assistance?**

Financial Assistance information and an application can be found on our website at WakeHealth.edu, or can be obtained by contacting Customer Service at 336-713-4955, by visiting the Cashier's Office at any hospital campus (Winston-Salem, Lexington or Davie) or by visiting any of our registration areas within the clinic or admitting office. Financial Assistance applications are available in both English and Spanish.

▶ **What information do I have to supply?**

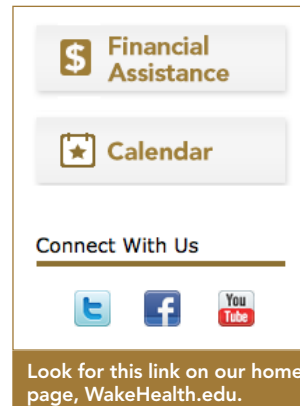
A financial application must be completed. In addition to the completed financial application, income documentation and proof of residency must be provided.

▶ **How do I know if I am eligible for a discount?**

Once your application is completed and income documentation and proof of residency are provided, a Wake Forest Baptist Health representative will process your information to determine a discount.

▶ **Can someone help me apply for financial assistance and explain the financial assistance program?**

Yes, assistance can be provided by contacting Customer Service at 336-713-4955, by visiting the Cashier's Office at any hospital campus (Winston-Salem, Lexington or Davie) or by speaking with a Financial Counselor at 336-716-0681.



The graphic is a vertical rectangular box with a gold border. At the top, there is a gold button with a white dollar sign icon and the text "Financial Assistance". Below that is another gold button with a white calendar icon and the text "Calendar". Underneath these buttons is the text "Connect With Us" in a small font, followed by a horizontal line. Below the line are three social media icons: Twitter, Facebook, and YouTube. At the bottom of the box, there is a gold background with white text that reads "Look for this link on our home page, WakeHealth.edu."

Lexington Medical Center

**FOR INTERNAL USE ONLY**

Today's Date: \_\_\_\_\_ Date Referred: \_\_\_\_\_  
Referred By: \_\_\_\_\_ Ins: \_\_\_\_\_  
CPI # and Visit #(s): \_\_\_\_\_ MRN #: \_\_\_\_\_  
Admit/Discharge Date(s): \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Procedure: \_\_\_\_\_  
Est. Charges: \_\_\_\_\_ Est. Pt. Bal. \_\_\_\_\_ Est. LOD: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ County of Residence: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Is the patient a U.S. citizen? \_\_\_\_\_ If no, is the patient a legal resident? \_\_\_\_\_

**Immediate Family Members Living in the Home:** (Younger than age 18 or a full-time student)

Relationship: \_\_\_\_\_ Name: \_\_\_\_\_ DOB \_\_\_\_\_ SSN: \_\_\_\_\_  
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**Employment Information for Patient/Parent/Legal Guardian**

Employer: \_\_\_\_\_ How Long at Current Employer: \_\_\_\_\_  
Employee: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Hourly Wage: \_\_\_\_\_ Hours Worked per Week: \_\_\_\_\_  
How Often Paid: \_\_\_\_\_ Monthly Gross Pay: \_\_\_\_\_  
Date Last Worked: \_\_\_\_\_ Income While Out of Work: \_\_\_\_\_  
(If currently unemployed)

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How Often Paid: \_\_\_\_\_ Monthly Gross Pay: \_\_\_\_\_  
Date Last Worked: \_\_\_\_\_ Income While Out of Work: \_\_\_\_\_  
(If currently unemployed)

**Social Security Retirement / Disability / Survivor Income / SSI / Veteran / Child Support / Work First Family / Unemployment**

**Current Accessible Trust Fund**

Type: \_\_\_\_\_ Monthly Amt.: \_\_\_\_\_ Received by: \_\_\_\_\_ Date Began: \_\_\_\_\_

By my signature below, I certify that the above information is an accurate and complete statement of my current financial position, and I give my permission to verify this information. Wake Forest Baptist Health reserves the right to reverse a discount previously recorded if it is determined that additional third-party payer resources were available or the information provided was false.

**Signed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_