Onslow
MEMORIAL HOSPITAL
Where People Care

317 Western Boulevard
Jacksonville, North Carolina 28546
910.577.2345
www.onslowmemorial.org

APPLICATION FOR PATIENT ASSISTANCE PROGRAM

Patient's Name: _____ DOB: _____
Address: _____
_____ Phone Number: _____

Household Family Members: Total Family Size: _____

Name	Date of Birth	Relationship	Income

I certify that the above information is true and accurate to the best of my knowledge. I will apply for financial assistance from other parties (Medicaid, Medicare, Insurance, etc.) that may cover the costs of my healthcare and I agree to assign or pay to the hospital/clinic any covered benefits to which I am entitled.

I understand that this application will be used by the hospital/clinic to determine my eligibility for the Patient Assistance Program using criteria established by and kept on file in the hospital/clinic. I understand that providing untrue/inaccurate information will result in being disenrolled from the clinic and that the hospital may take additional actions it deems appropriate.

Date: _____ Signature: _____

FOR INTERNAL USE ONLY

Date delivered to Provider: _____ Received by: _____
Household Salary: _____ Other Household Income: _____
Total Household Income: _____

Acct. Number	Date	Amount Owed	Acct. Number	Date	Amount Owed

On _____ **I NOTIFIED THE ABOVE NAMED PATIENT THAT:**
_____ He/She was eligible for the Patient Assistance Program
_____ He/She was not eligible for the Patient Assistance Program
_____ A determination as to eligibility will be delayed because _____
_____

Date: _____ Signature: _____ Title: _____