FINANCIAL ASSISTANCE APPLICATION 2025

Carteret Health Care is happy to extend this application to you for our Financial Assistance Program. This program is offered to all patients with or without health insurance who have outstanding balances at Carteret Health Care. Please complete the application and return with all the supporting documentation outlined below. Your request will be processed for qualification of an adjustment. The adjustment percentage is based on the information you provide in combination with the Federal Income Guidelines. You will be notified by email or mail of the final determination.

THIS PROGRAM ONLY COVERS CARTERET HEALTH CARE BILLS*APPLICANTS WILL NEED TO CONTACT THIRD PARTY BILLERS DIRECTLY; including but not limited to, Acute Care Solutions, Radiologists, Anesthesiologists, Pathology and/or Laboratory companies.

Please locate the one number that best describes your means of income below and provide all required documents listed. *Please do not send originals of requested tax and financial information. Incomplete applications will not be accepted and will be returned.* ***The only three forms of proof of income accepted are: 1040 Federal Tax Return, Social Security Award Letter or Disability Award Letter. The final page of the application, the 4506-T Form is only used if you did not file taxes and did not collect Social Security/Disability OR if you need a copy of your 1040 Federal Tax Return mailed to you by the IRS. CPA's/Tax Preparers and online tax filing companies can provide you with a copy of your return should you need it.***

1. Patient that filed taxes

- Applicant Information Form **Please include current mailing address, sign and date.*
- *Complete* 2024 Federal Income Tax Return and all supporting schedules listed on Schedule 1. *If applicable, schedules may include, Schedules C, D, E etc. /Misc. Forms which will be outlined in detail on the Schedule 1 with corresponding income reflected.*
- Medicaid Screening /Letter of denial of Medicaid, or a copy of valid Medicaid card.

2. Patient that did not file taxes

- Applicant Information Form **Please include current mailing address, sign and date.*
- Signed/Notarized Statement of Non-Filing of Taxes-***must be signed in front of a notary.***
- Verification of Non-Filing of Taxes Letter from IRS - *Applicant must fill out 4506-T Form, check box #7 and mail the completed form to the address listed on the back of the form themselves. The IRS will then process your request and mail the Verification of Non-Filing Letter directly to you. You will submit the letter at the same time as the other documentation listed in this section.*
- Proof of Income of supporting party. The only forms of income accepted are: 1040 Federal Tax Return or Social Security/Disability Award Letter. *SSA-1099/Disability-1099 not accepted.*
- Medicaid Screening/Letter of Denial of Medicaid or copy of valid Medicaid card.

3. Patient that did not file taxes and collects Social Security

- Applicant Information Form **Please include current mailing address, sign and date.*
- Signed/Notarized Statement of Non-Filing of Taxes-***must be signed in front of a notary.***
- Social Security Award Letter. *SSA-1099 not accepted.*
- Medicaid Screening/Letter of Denial of Medicaid or copy of valid Medicaid card

4. Patient that did not file taxes and collects Social Security Disability

- Applicant Information Form **Please include current mailing address, sign and date.*
- Signed/Notarized Statement of Non-Filing of Taxes-***must be signed in front of a notary.***
- Disability Award Letter. *Disability-1099 not accepted.*

For any questions regarding the Financial Assistance Application, please feel free to contact Whitney Chigas, Financial Assistance Program Coordinator.
Email: wbchigas@carterethealth.org Phone: (252) 499-6517 **Once completed, please return the application with supporting documents by email to: wbchigas@carterethealth.org or by mail to: Attn: Financial Assistance Program Coordinator 3500 Arendell St. Morehead City, NC 28557**

2025 Applicant Information Form

Patient Name: _____ DOB: _____ Medical Record#:_____

Patient Name: _____ DOB: _____ Medical Record#:_____

Mailing Address for Determination Letter: _____

Primary Phone #: ( ) _____

Email Address for Electronic Copy of Determination Letter: _____

Do you collect Disability? _____ Do you collect Social Security? _____ Are you covered by Medicaid*? _____

Are you financially supported by another party?_____ List name and relation:_____

As part of the CHC Financial Assistance Application process, every applicant must be screened for Medicaid. Medicaid screenings may be completed by appointment by contacting your local Department of Social Services, or by contacting the Carteret Health Care Advocatia Field Representative at (252) 499-6570, for an over the phone screening. Screenings and letters must be dated within the last 90 days. If you currently have Medicaid, please submit a copy of your valid Medicaid card. Applications missing Medicaid documentation will be returned

I have enclosed *all information* for my income category as:
(check **ONE** only)

◯ Patient that filed taxes ◯ Patient that collects Social Security/Disability and *did* file taxes
◯ Patient that did not file taxes ◯ Patient that collects Social Security/Disability and *did not* file taxes

I hereby certify that, to the best of my knowledge, the provided financial information is true and accurate.

Patient Signature _____ Date ____/_____/____

Spouse Signature _____ Date ____/_____/____

For any questions regarding the Financial Assistance Application, please feel free to contact Whitney Chigas, Carteret Health Care Financial Assistance Program Coordinator: Email: wbchigas@carterethealth.org Phone: (252) 499-6517
Once completed, please return the application with supporting documents by email to: wbchigas@carterethealth.org **or by mail to:** Attn: Financial Assistance Program Coordinator 3500 Arendell St. Morehead City, NC 28557.
➡ *Please contact our payment department for payment arrangements as accounts are not placed on hold during the application process and require a payment every 30 days to avoid collection activity. Pre-approvals for the program are not granted and accounts relating to a liability, accident, crime or lawsuit and elective/cosmetic surgeries are ineligible.*

Statement o***f Non-Filing of*** 2024 Taxes

- If you ***did not*** and ***do not plan*** to file Federal Income Taxes due to limited or no income, you must ***sign and*** have the statement below ***notarized***.
- If you ***do not have any income*** to report or are being financially supported by another person, you must ***sign, along with your supporting party, in front of a notary***. Financial support includes shelter, food, living expenses, etc. You will need to provide proof of income of your supporting party with your application. The 1040 Federal Tax Return or Social Security/ Disability Award Letters are the only forms of income accepted. *Refer to page 1 of the application for the checklist of documentation needed in addition to this form for 'Patient that did not file taxes' category.*

I, _____ do hereby swear that on this _____ day of _____, ____,

I ***Did Not*** and ***Do Not Plan*** to file Federal Income Taxes for the year due to limited or no income. I am being financially supported by: Self_____ Spouse_____ Parent_____
Other (please specify) _____.
This is for the purpose of receiving financial assistance at Carteret Health Care.

_____ _____/_____/____
Applicant Signature Date

_____ _____ ___/____/____
Person Financially Supporting Applicant Relationship to Applicant Date

I, _____, a Notary Public for _____ County, North Carolina, do hereby certify that _____ personally appeared before me and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal, this the _____ day of _____, ____.

_____ ____/____/____
Notary Day