Date
Patient Name
Address
City, State, Zip

Thank you for your interest in The UNC Health Financial Assistance program. The program helps relieve the financial burden of eligible health care services at participating UNC Health entities. To qualify, you must be a **North Carolina resident** with a household income at or below 250% of the Federal Poverty Guideline for your family size, including assets. To apply, please complete the attached application and submit it, along with the required documents, by secure fax at 984-974-6425, securely through My UNC Chart, or US postal mail.

Regular billing will continue until the application and all required documents are received. If you have questions, call the Financial Assistance Unit at 984-974-3425 or toll-free at 866-704-5286 Monday – Thursday 8:30 a.m. – 4:30 p.m. and Friday 8:30 a.m. – 12:30 p.m.

Required Documents to Submit with Application

- **North Carolina Medicaid:** If you do not have health insurance, you are required to be screened for Medicaid Eligibility. If eligible, you will be required to apply for NC Medicaid and show proof of a decision as part of the financial assistance application. To be screened, contact your local Department of Social Services or call the Financial Assistance Unit at 984-974-3425 or toll-free at 866-704-5286.
- **North Carolina Residency:** Provide two proofs of NC residency with the current NC address where you live. See the NC Residency documents list attached for acceptable documents.
- **Income:** Provide **the most recent 30 days of gross income** for the patient, spouse, guarantor, parents (if the patient is a minor), and all adult dependents 18 years of age and older. Income proof includes but is not limited to pay wages, self-employment income, Social Security award letter, Veterans benefits letter, pension or retirement, unemployment benefits, disability award letter, and alimony documentation.
- If you **do not** have any income, include a letter of support, signed and dated, from the person who provides you with support. You may also provide documentation of support services such as rental income assistance, SNAP benefits, and utility assistance.
- **Assets:** Provide proof of assets for the patient, spouse, guarantor, parents (if the patient is a minor), and all adult dependents 18 years of age and older. Assets include but are not limited to bank accounts including checking, savings, money markets, stocks, investments, retirement, or Go Fund Me accounts. Send all pages of the most recent month statements. The last four digits of the account number must be visible. ***Transaction summaries are not accepted***

- **Tax Return:** Submit a copy of the most recent year Federal 1040 Tax Return including all schedules. If you do not have a copy of your tax return, call the IRS at 1-800-829-1040 for a free transcript.
- **Property:** If you own property other than your primary residence, provide a copy of most recent year Property Tax Document or proof of rental income.
- **Other Items:** If you do not file taxes and include dependents on your application, provide copies of birth certificates or custodian documents for all minors, marriage certificate (if married), and death certificate if patient is deceased.

Financial Assistance walk-in support is available at 1101 Weaver Dairy Road, Suite 106, Chapel Hill, NC 27514 Monday through Friday from 8:00 a.m. - 4:00 p.m.

Thank you,

UNC Financial Assistance Unit

UNC Financial Assistance Application
101 Manning Drive, Chapel Hill, NC 27514
Secure fax: 984-974-6454
Phone: 866-704-5286 or local 984-974-3425

I: NC Medicaid Requirement

If you do not have health insurance, you are required to be screened for NC Medicaid eligibility. If eligible, you are required to apply for NC Medicaid and show proof of the decision to be considered for UNC Financial Assistance. Contact your local Department of Social Services or call the Financial Assistance Unit at 984-974-3425 or toll-free 866-704-5286.

I do not require screening for Medicaid eligibility because I currently have:

☐ Health Insurance ☐ Medicaid / Medicare ☐ Medicaid Family Planning Only

☐ Screened not eligible by a referring health center (copy of screening required)

II: Patient or Guarantor Information (if patient is a minor)

Name (Last, First, Middle Initial)	Birth Date (mm/dd/yyyy)	Guarantor or Medical Record No.	
Address	City	State	ZIP Code
Phone Number	Email Address (optional)	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow	
Employment Status ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student	Employer Name	Employer Phone Number	

III: Spouse Information

Name (Last, First, Middle Initial)	Birth Date (mm/dd/yyyy)	Phone Number
Employment Status ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student	Employer Name	Employer Phone Number

UNC Financial Assistance Application
101 Manning Drive, Chapel Hill, NC 27514
Secure fax: 984-974-6454
Phone: 866-704-5286 or local 984-974-3425

IV: Household Dependents

Dependents on your federal tax return that you provide more than 50% support.

Full Name	Relationship	Date of Birth	Medical Record No.
1.			
2.			
3.			
4.			
5.			

V: Household Income and Assets

1. **Do you have bank accounts?** ☐ **YES** ☐ **NO** **If yes, Bank Name:**_____ **Type of account:** ☐ **Checking** ☐ **Savings** ☐ **Investments** ☐ **Retirement**
   *If yes, provide most recent month statement for each account.

2. **Do you own property OTHER than your primary residence?** ☐ **YES** ☐ **NO**
   *If yes, include property tax document. If a rental property, provide proof of rental income.

3. **Did you file taxes this year?** ☐ **YES** ☐ **NO**
   *If yes, provide a copy of the 1040 Federal Tax Return including all schedules.

VI: Advocate (Optional)

If an advocate is assisting you with the application process, please include the name and phone number. By providing the advocates contact information, you give us permission to speak to them on your behalf.

Name of Advocate:_____ Phone:_____

Additional Comments:

VII: Signature and Date Required

I certify that all information listed is true to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I give permission for UNC Health and all affiliated clinics, hospitals, and entities to verify the information provided on this application.

Patient or Guarantor Signature	Sign Date (mm/dd/yyyy)

UNC Financial Assistance Application
101 Manning Drive, Chapel Hill, NC 27514
Secure fax: 984-974-6454
Phone: 866-704-5286 or local 984-974-3425

NC Residency Requirements

In order to meet state residency requirements, North Carolina must be your fixed, established or permanent place of residence with the intention to stay there permanently or for an indefinite period.

To verify NC residency, provide **two** documents from the list below. The documents must be in the name of applicant or applicant's legal spouse and **show the current North Carolina address**.

a. A valid North Carolina drivers' license or other identification card issued by the North Carolina Division of Motor Vehicles.

b. A current North Carolina lease or mortgage document, bank statement, or current utility bill, motor vehicle registration, or voters registration card.

c. Tax return

d. A document verifying North Carolina employment.

e. One or more documents proving that the applicant's home in the applicant's prior state of residence has ended, such as closing of a bank account, termination of employment, or sale of a home.

f. A document showing that the applicant has registered with a public or private employment service in North Carolina.

g. A document showing that the applicant has enrolled his children in a public or a private school or a childcare facility located in North Carolina.

h. A document showing that the applicant is receiving public assistance (such as Food Stamps) or other services which require proof of residence in North Carolina. Work First and Energy Assistance do not currently require proof of NC residency.

i. Records from a health department or other health care provider located in North Carolina.

j. A written declaration from an individual who has a social, family or economic relationship with the applicant, and who has personal knowledge of the applicant's intent to live in North Carolina permanently, for an indefinite period of time, or residing in North Carolina in order to seek employment or with a job commitment.

k. A document from the US Department of Veteran's Affairs, US Military or the US Department of Homeland Security verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or has a job commitment.

UNC Financial Assistance Application
101 Manning Drive, Chapel Hill, NC 27514
Secure fax: 984-974-6454
Phone: 866-704-5286 or local 984-974-3425

l. Official North Carolina school records, signed by school officials, or diplomas issued by North Carolina schools (including secondary schools, colleges, universities, community colleges), verifying the applicant's intent to live North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or with a job commitment.

m. A document issued by a foreign consulate verifying the applicant's intent to live in North Carolina permanently or for indefinite period of time, or that the applicant is residing in North Carolina to seek employment or has a job commitment.

NC Residency Declaration

I verify that I CANNOT provide two North Carolina state residency verification documents. By signing below, I affirm and represent that I am a North Carolina resident.

I hereby declare that the above information is true and accurate. I understand that this declaration form is used to help verify that I meet North Carolina state residency requirements for UNC Health Care Financial Assistance. I understand that a false or misleading declaration by me may result in Charity Care adjustments for which I would not otherwise have qualified and may subject me to civil and criminal penalties.

Patient Signature		Sign Date
Address	City	State
ZIP code	Primary Phone	