"Rex Assist" Application
Patient Financial Services
4420 Lake Boone Trail
Raleigh, NC 27607
Toll-Free Rex Assist Help Line (866) 687-7674
Fax Number (919) 784-1697

IMPORTANT: To be considered for Charity Care for medically necessary services, this confidential application must be completed. To be considered complete, the following **must be attached. IF ALL REQUIRED DOCUMENTATION IS NOT RECEIVED, REVIEW OF APPLICATION WILL BE DELAYED. ORIGINALS WILL NOT BE RETURNED**

- Most recent Federal Income tax return (All pages required) **for patient and spouse** (if applicable)
- Last 6 weeks' pay stubs **OR** documents of unemployment from the NC Employment Security Commission **OR** Social Security Statement **for patient and spouse OR** if you have no household income, a signed statement of support from the person who meets your daily financial needs such as housing, food, and clothing **OR** Full-time Student status document
- Last 3 months' (**all pages**) checking/savings/investment bank statements **for patient and spouse** – statement format
- Proof of Medicaid eligibility (if applicable)
- If recently unemployed, are you eligible for Cobra? Yes / No - Cobra Name and Address_____

I. PATIENT INFORMATION

Patient Name: _____ Rex Hospital Patient Account #: _____ Marital Status: _____ U S Citizen Y__N___

VISA Y__ N___ Social Security #: _____--_____--_____ Date of Birth: _____/_____/_____Age _____ Gender M F

II. GUARANTOR INFORMATION (Person legally responsible for bill)

Last Name	First Name	M.I.	Social Security #
			- -

Rex Hospital Account Number	Relationship to Patient	Area Code- Phone Number
		( )

Address	City	State	Zip	County

Employer	Phone Number
	( )

Patient's Legal Spouse *or* Parent if Patient is a Minor	Spouse/Parent Medical Record #	☐ Spouse ☐ Parent	Spouse/Parent Social Security Number

Spouse/Parent Employer	Phone Number
	( )

III. OTHER ELIGIBLE DEPENDENTS/SPOUSE/PARENT IF PATIENT IS A MINOR or Full-time student – Total Number in Household_____

First Name	Last Name	Rex Healthcare Medical Record #	Relationship to Guarantor or Patient	Date of Birth

IV. OTHER FINANCIAL INFORMATION

Bank(s) Name(s): _____ ☐ Checking ☐ Savings

Total of all family's checking account balances: $ _____ Total of all family's savings account balance: $ _____

Real estate owned other than primary residence: Amount Owed on Mortgage: $_____ Tax Value: $ _____ County/State:_____

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V. INCOME INFORMATION

Income Source	Monthly Amount	Monthly Expenses	Monthly Amount
Guarantor's Income (before taxes)	$	Rent and/or Mortgage	$
Guarantor's Second Job Income (if any)	$	Land Mortgage	$
Spouse's Income (before taxes)	$	Property Tax	$
Spouse's Second Job Income (if any)	$	Home/ Car / Fire Insurance	$
Farm/Self- Employment Income	$	Food	$
Unemployment Compensation	$	Electricity	$
Worker's Compensation	$	Heat (gas, oil, wood, kerosene)	$
Retirement Pension/ SSD/SSI (please circle)	$	Water/Sewer/Garbage	$
VA Benefits	$	Telephone	$
Stocks	$	Cable TV	$
Bonds	$	Internet	$
Money Markets	$	Vehicle/Auto Payment	$
CD's	$	**Health Insurance / Name-_____**	$
Interest/Dividends	$	Burial or Life Insurance	$
Rental Income	$	Child Support	$
Estates/Trusts/Legal Settlements	$	Child Care/Tuition	$
Alimony	$	Transportation	$
Aid to Families with Dependent Children (Work First)	$	Bank and/or Student Loans	$
Strike Benefits from Union Funds	$	Medicines/Supplies	$
Other 1 _____	$	Credit Cards	$
Other 2_____	$	Other 1_____	$
Other 3_____	$	Other 2 _____	$
Other 4_____	$	Other 3 _____	$
Total Monthly Income	**$**	**Total Monthly Expenses**	**$**

I certify that the answers written above and any additional information and/or income that I have listed on a separate sheet are true to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I authorize the release of any information needed to verify the information provided. I give my social security number voluntarily and have permission to provide the social security numbers of other eligible dependents listed above. I understand that UNC Health Care System may use social security numbers for the purpose of accurate identification, filing insurance claims, billing, collections and compliance with Federal and state laws.

VI. PATIENT/GUARANTOR ADDITIONAL COMMENTS (If Federal taxes not filed, please explain why):

_____

_____

_____

_____

Please send copies only. ORIGINALS WILL NOT BE RETURNED.

VII. ☒_____ _____

PATIENT OR GUARANTOR SIGNATURE **DATE**

**********FOR OFFICE USE ONLY**********

Received By: _____ **Recommendation: _____**

Date: _____ **Approved By: _____Date_____**