Orange Regional Medical Center Financial Aid Application

Patient Name: _____ORMC Account#_____
Patient SS#: _____Date of Birth_____Patient Phone #_____
Patient Address: _____
_____ **Rent**: _____
Guarantor Employer: _____
Occupation: _____

List members of your household

Name	***Date of Birth***	***Relationship to Patient***

List *all* household income:

Source	***Name***	***Monthly Income***
Wages		
Self Employment Earnings		
Social Security Income		
Pension		
Compensation		
Unemployment		
Child Support		
Alimony		
Resources (Checking/Savings, etc.)		

Documentation Required
Photo identification
Proof of income: Most recent paystubs (2)
Other income verification, if applicable: Unemployment Statement, Social Security Award Letter, Pension Letter, Child Support Letter
Proof of address, i.e. rent receipt, utility bill
Bank statements – Recent statement(2)

I hereby request a written determination of Financial Aid eligibility by Orange Regional Medical Center. I understand that all income and family size information provided is subject to verification by the Hospital. I further understand that if the information provided is found to be false, such determination will result in a denial of Financial Aid and I will be responsible to pay for services rendered. I swear all statements in this application are true and correct to the best of my knowledge. I give permission to Orange Regional Medical center to verify any information pertinent to this application. This will serve as a release for income verification.

_____ _____
Signature of Applicant/Representative Date