Financial Assistance Application

Patient/Guarantor Information

Patient's Name: ____

Guarantor's Name (if patient is under 18 years of age): ________________________________

Patient's Address: ____

City: _____________ **State/ZIP:** ______________________ **Patient's Date of Birth:** ______________

Patient's Medical Record Number: _________________

Current Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse Information

Spouse's Name: ____

Spouse's Address (if different from patient): _______________________________________

City: ______________ **State/ZIP:** ____________________ **Spouse's Date of Birth:** ________________

Spouse's Medical Record Number: _________________

Note: If you are married, then spouse's financial information and signature is required in order for application to be processed.

Household Information

Household Size/Dependents (including yourself & spouse): ____________________________

Please provide dependents name, Date of Birth, and Medical Record Number (if applicable)

Household Income (Gross): ____

Income is defined as wages, profits from business, rental income from rental properties, social security income [SSI/SSDI], income from investments, retirement/pension, alimony, etc.

Employment Information

Patient/Guarantor

- ☐ Employed
- ☐ Self-Employed
- ☐ Unemployed
- ☐ Full time student
- ☐ Dependent on Others
- ☐ Retired

Spouse

- ☐ Employed
- ☐ Self-Employed
- ☐ Unemployed
- ☐ Full time student
- ☐ Dependent on Others
- ☐ Retired

Please send proof of monthly household income by providing one of the documents listed below. If you claim dependents you must provide a tax return.

(Pay Stubs, SSI/Disability, W2/Retirement/Pension, Tax Returns, Letter from Employer).

If no income, please provide explanation of how you pay daily living expense:

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☐ **Please Check Box if you authorize us to update your demographic information (Address, Marital Status, etc.)**

Patient/Guarantor's Signature: ______________________________________ Date: _________________

Spouse's Signature: ____ Date: _________________

Send Completed Financial Assistance Application to:

Fax: 919-620-1241
Email: PRMOSelfPayReimb@dm.duke.edu
Mail: PRMO Self-Pay
PO Box 110566
Durham, NC 27709

Contact Information: 919-620-4555 or 800-782-6945

Please allow 4-6 weeks for processing

Additional Comments