LifeBrite
COMMUNITY HOSPITAL OF STOKES

Financial Assistance Application

Dear Patient/Guarantor,

Thank you for choosing Lifebrite Community Hospital of Stokes and its affiliated clinics for your healthcare needs. We would like to assist you with your financial obligation by offering the Financial Assistance Application. If you have any questions about the required documents or the application please feel free to ask a representative, or you may call to speak with a Financial Services Representative at (336) 593-2831.

Please return the completed, signed, and dated application along with the list of required documents (see below) back to Lifebrite Community Hospital of Stokes or the affiliated clinic within 2 weeks. Your application is due back by: _____.

If you have circumstances, you feel are important to your financial situation, please include a signed letter of explanation with the documents.

Required Documents:

1) Medicaid Denial Letter if requested by facility or clinic
2) Most recent prior year's tax returns including W2s/1099s/Schedule C
3) Proof of household income
   a) If working, paycheck stubs for the previous month
   b) If unemployed and receiving unemployment check, provide check stub or unemployment compensation determination letter
   c) If income if from a retirement fund, pension, rental property, etc. provide proof of the source and amount of income received
4) If household income has changed since last tax return, provide a written explanation
5) Proof of disability/physicians work order restriction
6) Outstanding medical bills other than bills at Lifebrite Community Hospital of Stokes
7) Rent or mortgage payment receipt for one month
8) Utility bills: gas, electric, water and sewage
9) Three months bank statements (checking and savings)

Approval is based on a sliding scale methodology for 2025 poverty level listed below

Family Size	Annual FPL	100% Monthly FPL	200% Monthly FPL	250% Monthly FPL	300%PL	400 % Monthly FPL
1	15,650	1,304	2,608	3,260	3,913	5,217
2	21,150	1,763	3,525	4,406	5,288	7,050
3	26,650	2,221	4,442	5,552	6,663	8,883
4	32,150	2,679	5,358	6,698	8,038	10,717
5	37,650	3,138	6,275	7,844	9,413	12,550
6	43,150	3,596	7,192	8,990	10,788	14,383
7	48,650	4,054	8,108	10,135	12,163	16,217
8	54,150	4,513	9,025	11,281	13,538	18,050
Each Additional Person	5,500	458	917	1,146	1,375	1,833

LifeBrite
COMMUNITY HOSPITAL OF STOKES

Patient(s) Applying for Financial Assistance: _____

Patient and/or Guarantor information if patient is a minor:

Name: _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____
Social Security #: _____ Marital Status: _____

Spouse and/or Guardian information:

Name: _____ Date of Birth: _____
Social Security #: _____

For questions regarding income, please include everyone in your family that lives in the same household who share income, food and/or rent. This number includes you, your spouse, and/or any dependents.

Household Employment:

Name	Relationship	Employer	Salary/Hourly Rate	# Hours Worked Weekly

Additional Sources of Income:

Unemployment:	Self-Employment:
Social Security:	Pension Funds:
Disability:	Savings Trust:
VA Benefits:	Child Support:
Public Assistance:	Food Stamps:
Other:	

Total Monthly Income: $_____**Total Number in Household**: _____

Dependents:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Use separate sheet of paper if necessary.

To the best of my knowledge the information given is true and correct. I give permission to Lifebrite Community Hospital to verify information regarding my financial status. I understand failure to return information within two weeks will result in responsibility for the full amount of services.

_____

Patient Printed Name | Patient Signature | Date