



Raleigh Radiology Financial Assistance Application Instructions

Application Overview

Please carefully review this application in its entirety. If the required application and supporting documents are not submitted, your application may be denied, suspended, or delayed. After we receive and review your application, please allow a processing period of 4–6 weeks. The Financial Assistance Program applies to Raleigh Radiology locations including Raleigh Radiology WakeMed JV locations, and the professional interpretation component of exams performed at WakeMed and read by Raleigh Radiology. Once your application has been processed, you will receive either an approval or a denial letter. If your application is denied, the letter will include an explanation for the denial. Approved financial assistance is valid for six (6) months from the date of approval.

Program Purpose

Thank you for considering the Raleigh Radiology Financial Assistance Program. This program is intended to help qualified patients reduce their medical costs if they do not qualify for Medicaid, lack of insurance, are underinsured, are ineligible for government programs, or are unable to pay for their care due to their individual financial circumstances. Please note that elective services are not eligible for financial assistance.

Eligibility Criteria

To be eligible, North Carolina must be your permanent place of residence. The next page lists all required documents and provides further application instructions. You must have a household income below **275%** of the Federal Poverty Guidelines (FPG) for your family size - income requirements are detailed on the following page. Additionally, you must have a current outstanding balance with Raleigh Radiology.

Terminology Used in This Document

- **Guarantor:** The insurance policyholder who is financially responsible for payment. For example, if a child or adult is covered under a parent's insurance policy, the parent who holds the policy is considered the guarantor.
- **Elective Services:** These services are non-urgent, planned medical procedures that are scheduled in advance and are not immediate emergencies. Only procedures or services deemed medically necessary are considered for financial assistance.
- **Income:** Income is defined as any wages, profits from a business, rental properties, social security income, investments, retirement/pension, alimony, etc.

Applying for Medicaid

If you do not have health insurance, you may be eligible for North Carolina Medicaid. As part of the Financial Assistance Program, you must be screened for Medicaid eligibility. You can apply for Medicaid through ePASS <https://epass.nc.gov>, your local county department of Social Services, or by US mail. For assistance with your application, please contact your local county Department of Social Services at (984) 974-0950. Please provide Raleigh Radiology with proof of your Medicaid approval or denial. You may mail this documentation to the address listed on Page 3.

Family Household Size

Required: List the number of people living with you. Household members include:

- The patient and, if married, the patient's spouse
- Any natural or adopted minor child of the patient or spouse who is not emancipated by a court and has never been married
- Any minor for whom the patient or spouse has legal responsibility by court order
- Any person listed as a 'dependent' on the patient's latest tax return
- Any student over 18 years old who relies on the patient's family income for over **50%** of support
- Any other person dependent on the patient's family income for over **50%** of support
- Any minor child of a minor who is solely or partly supported by the minor who is part of the patient's family

Proof of Income

Submit one (1) of the following forms of proof of income for the patient and any household member above **18 years old**.

- Most recent filed tax return for the patient and spouse (submit all copies reflecting current income)
- For self-employed patients – Schedule C of the Federal Income Tax Return, self-employment verification form, or company profit and loss statement
- A personal letter stating current employment status for the patient and spouse (if applicable), including if either is unemployed or self-employed. The letter must include the household adjusted gross income (prior to taxes), applicant's printed name, current address, and signature.
- Most recent pay stubs for the last six (6) months for both the Guarantor/Patient and/or spouse if employed

Proof of North Carolina Residency

Submit two (2) forms of proof of residency. Acceptable documents include:

- Valid NC driver's license or ID card
- Current NC lease or mortgage document
- Current Utility Bill
- Vehicle Registration
- Documents from the US Department of Veterans Affairs, US military, or US Department of Homeland Security verifying the intent to live in North Carolina

Additional Required Documents (If Applicable)

You must submit the following if applicable. Failure to send these items will prevent your application from being processed. **Disclaimer:** If you were not receiving Disability, Medicaid, Social Security, or unemployment benefits on the date of your exam, you may not submit these valid documents for Financial Assistance. However, you may still qualify through other documentation or criteria.

- Disability letter
- Medicaid denial letter
- Social Security Benefit Statement



Unacceptable Documents

The following documents are not accepted as proof in Income or NC Residency.

- Tax Transcripts
- 1099 Forms
- Personal Checks (in place of paystubs)

Document Checklist

Ensure that the following documentation is included in your application.

- Two forms of proof of residency
- Most recent tax return
- Six weeks of pay stubs
- Other applicable documents

Submission Instructions

Please submit the following required documents.

1. Completed Financial Assistance Application
2. Proof of Income
3. Two (2) forms of Proof of Residency
4. Additional items, if applicable

Mailing Instructions

Disclaimer: At this time, your Financial Assistance Application and supporting documents may only be submitted by US mail. It is highly recommended that you send your documents by certified mail for tracking purposes. Raleigh Radiology is not responsible for any lost applications or supporting documents. Please do not deliver your application in person; the address is for mail services only.

Mail to:

Attention: Raleigh Radiology Financial Assistance

**5220 Greens Dairy Road
Raleigh, NC 27616**

For inquiries/further clarifications on applying for Financial Assistance, please contact (919) 533-3186. When leaving a message, please include your name, date of birth, contact number, and a brief description of your call; your call will be returned within 24-48 hours. Disclaimer: Please do not leave any personal information, for example, such as social security numbers, bank account information, credit card numbers.



Federal Poverty Guidelines

	225% of Poverty Guidelines	250% of Poverty Guidelines	275% of Poverty Guidelines
Family Size	100% Discount	90% Discount	80% Discount
1	Household income below \$35,212.50	Household income below \$39,125.00	Household income below \$43,037.50
2	Household income below \$47,587.50	Household income below \$52,875.00	Household income below \$58,162.50
3	Household income below \$59,962.50	Household income below \$66,625.00	Household income below \$73,287.50
4	Household income below \$72,337.50	Household income below \$80,375.00	Household income below \$88,412.50
5	Household income below \$84,712.50	Household income below \$94,125.00	Household income below \$103,537.50
6	Household income below \$97,087.50	Household income below \$107,875.00	Household income below \$118,662.50
7	Household income below \$109,462.50	Household income below \$121,625.00	Household income below \$133,787.50
8	Household income below \$121,837.50	Household income below \$135,375.00	Household income below \$148,912.50



Financial Assistance Application Form

Patient Information

Patient Name: _____ DOB(MM/DD/YYYY): _____ Pt Acct. #(Optional): _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Contact Number: _____ Cell Number Home Number

Marital Status: Single Married Separated Divorced Widowed

Is the patient deceased? Yes No If yes, please also attach a copy of the death certificate to the application.

Guarantor (Responsible Party) Information – If Not the Patient

Guarantor Name: _____ DOB(MM/DD/YYYY): _____ Pt Acct. #(Optional): _____

Address (if different from patient): _____ City: _____ State: _____ Zip: _____

Is Guarantor a resident of NC? Yes No

Spouse Information

Name: _____ DOB(MM/DD/YYYY): _____ Pt Acct. #(Optional): _____

Address (if different from patient): _____ City: _____ State: _____ Zip: _____

*If married, the spouse’s financial information and signature is required in order for the application to be processed.

Household Member Information

Total number of household members (including yourself and spouse): _____

Name: _____ DOB (MM/DD/YYYY): _____ Relationship: _____

Household Income (Gross): _____

*Income is defined as any wages, profits from a business, rental properties, social security income, investments, retirement/pension, alimony, etc.

Employment Status – Patient

Employment Status: Full Time Part Time Unemployed Retired Full Time Student

Current Employer: _____ Dates of Employment (MM/YYYY): _____ To (MM/YYYY): _____

Employer Phone Number: _____ Salary: _____ Hr. Wk. Mo. Yr. Hours per week: _____

***If Unemployed or on Social Security, you must submit documentation with your application**

Secondary (if applicable): _____ Employment Status: Full Time Part Time

Dates of Employment (MM/YYYY): _____ To (MM/YYYY): _____

Employer Phone Number: _____ Salary: _____ Hr. Wk. Mo. Yr. Hours per week: _____

Employment Status – Guarantor (Responsible Party) – If Not the Patient

Employment Status: Full Time Part Time Unemployed Retired Full Time Student

Current Employer: _____ Dates of Employment (MM/YYYY): _____ To (MM/YYYY): _____

Employer Phone Number: _____ Salary: _____ Hr. Wk. Mo. Yr. Hours per week: _____

***If Unemployed or on Social Security, you must submit documentation with your application**

Secondary (if applicable): _____ Employment Status: Full Time Part Time

Dates of Employment (MM/YYYY): _____ To (MM/YYYY): _____

Employer Phone Number: _____ Salary: _____ Hr. Wk. Mo. Yr. Hours per week: _____

Employment Status - Spouse

Employment Status: Full Time Part Time Unemployed Retired Full Time Student

Current Employer: _____ Dates of Employment (MM/YYYY): _____ To (MM/YYYY): _____

Employer Phone Number: _____ Salary: _____ Hr. Wk. Mo. Yr. Hours per week: _____

***If Unemployed or on Social Security, you must submit documentation with your application**

Secondary (If applicable): _____ Employment Status: Full Time Part Time

Dates of Employment (MM/YYYY): _____ To (MM/YYYY): _____

Employer Phone Number: _____ Salary: _____ Hr. Wk. Mo. Yr. Hours per week: _____

Assets (please put N/A if any assets do not apply to you)

Assets	Amount
Primary Residence	\$
Other Real Estate	\$
Bank Accounts (Total)	\$
Retirement Accounts	\$
Stocks	\$
Mutual Funds	\$
Trust Accounts	\$
Other	\$
Cash Value of Life Insurance	\$
Total Assets	\$
Lottery Winnings	\$

Liabilities (please put N/A if any assets do not apply to you)

Liabilities	Amount	Monthly Payment
Mortgage Balance	\$	\$
Loans against Life Insurance	\$	\$
Bank Credit Cards	\$	\$
Other Cards	\$	\$
Utilities (Per Month)	\$	\$
Rent	\$	\$
Other Vehicles	\$	\$
Other	\$	\$
Total Debt	\$	\$

Certification of Information

I authorize the release of the information listed on this application, to and from my employer and/or the holder of this information, for the purpose of verifying my income status and assisting with the payment of my medical bills. Patient

Signature: _____ Date: _____

Spouse Signature (if applicable): _____ Date: _____