



CAFA Overview

The information requested in this application is required to determine eligibility for Coverage Assistance and Financial Assistance (CAFA). CAFA is a financial assistance program for uninsured patients who have received hospital services. Eligibility is based on a patient's household income as compared to federal poverty guidelines.

Requirements to Apply for CAFA

To be considered for CAFA:

- the patient must be uninsured
- the patient must be a resident of North Carolina or South Carolina
- the patient must not be potentially eligible for other programs (such as Medicaid) or has fully cooperated in applying for another program but did not qualify
- the patient must fully cooperate with the CAFA review process. If additional information and/or proof of income is needed to complete the application, a letter will be mailed to the patient to let them know what is needed and the deadline to submit. If the information requested is not received by the deadline, the patient will not be eligible for CAFA.

What to Expect: The Eligibility Review Process

Eligibility will be determined within 45 days from the date the application is received by the Coverage Assistance Services Team at Atrium Health. If proof of income is needed, the review process may extend past 45 days and be completed upon receipt of the information requested. Once the eligibility review is complete, a letter will be mailed the patient to let them know if they have been approved or denied.

Please complete all 3 pages of this form. Filling out this form completely will help to prevent delays in the review process.

Patient Information			
Patient Name	Social Security#	Date of Birth	Account#

Applicant Information				
Applicant Name	Relationship to Patient	Social Security#	Date of Birth	Marital Status
Address		City, State and Zip Code		
Home Phone#	Mobile Phone#	Emergency Contact Name	Emergency Contact Phone#	
Employer Name	Employer Address		Work Phone	

NOTE: If the address where you receive mail is different from the address where you live, please fill out the 'mailing address' information below

Mailing Address	City, State and Zip Code
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Health Insurance Information				
<input type="checkbox"/> Check this box if the patient <u>does not</u> have any source of health coverage				
Health Insurance Provider	Policy Holder Name	Policy#	Group#	Effective Date
Has a member of the household lost their job within the past 60 days?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did he/she receive a COBRA election notice?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did he/she elect COBRA coverage?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
If he/she did not elect COBRA coverage, please check one: <input type="checkbox"/> COBRA premiums too expensive <input type="checkbox"/> has new coverage				

Please list all household members below				
Name	Social Security#	Date of Birth	Relationship to Patient	
1				
2				
3				
4				
5				
6				

NOTE: please list any additional members of the household in the 'notes' section on page 3 of this form

Monthly Household Income		
Type of Income	Monthly Gross Income for Applicant	Monthly Gross Income for Applicant's Spouse
Employment Income	\$	\$
Retirement/Pension/Social Security Retirement	\$	\$
Social Security Disability Income	\$	\$
Unemployment Income	\$	\$
Child Support/Alimony	\$	\$
Other (list source here _____)	\$	\$

Statement of Support

I certify that I have been unemployed for the last _____ years / _____ months. As a result of being unemployed, I receive food, shelter and clothes from _____ (relationship to applicant = _____)

Acknowledgement and Signatures

I hereby certify that the information provided in this application is true, accurate and complete to the best of my knowledge. I hereby authorize the Hospital to contact any person, firm or organization to verify any of the information given and I hereby authorize any such person, firm or organization to release to the Hospital any financial information it may request.

Applicant Signature _____ Date _____

Mail Completed Application to:
Atrium Health Business Office
Attention: Coverage Assistance Services
PO Box 32861
Charlotte, NC 28232

Notes

