



Compassionate Care Program Application

Please fill out and return to: P.O. Box 16367, Asheville, NC 28816.

Questions? Please call us at (828) 252-8957, option 2.

PATIENT/RESPONSIBLE PARTY

Patient Name: _____

Acct. #: _____ SS#: _____

Responsible Party Name (if different from above): _____

Present Address: _____ No. of Years: _____ Own Rent

Street: _____

City/State/Zip: _____

Former Address (if less than 2 years at present address):

Street: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Position/Title: _____ Length of Employment: _____

Married Single Divorced Separated Widowed

Number of Dependents Other Than Spouse: _____ Ages: _____

SPOUSE (If separated, do not complete)

Name: _____

SS#: _____ Work Phone: _____

Employer: _____

Position/Title: _____ Length of Employment: _____

Number of Dependents (if not listed above): _____ Ages: _____

I, the undersigned, certify the information provided has been carefully completed and there are no omissions and this information is true and correct to the best of my knowledge. I understand that the completion of this form does not guarantee any adjustments on my account. Decisions will be made on a case by case basis. I also understand that to complete this application, **I must submit proof of income for all income-producing family members. Acceptable proof of income includes previous year's tax return, current payroll stub or W-2 form. **STD (Sexually Transmitted Disease) screening will not be covered by Compassionate Care**

Signature of Patient/Responsible Party

Date

Signature of Spouse

Date