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