

**VCU HEALTH SYSTEM  
FINANCIAL STATEMENT**

**Patient Information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MR# \_\_\_\_\_  
 SS#: \_\_\_\_\_ Marital Status \_\_\_\_\_ Citizen: Yes No Va. Resident: Yes No  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
 (If self-employed, identify type of business)  
 Employer Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Spouse/Guarantor Information:**

Name: \_\_\_\_\_ Relationship:  Spouse  Child  Parent  other  
 Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ DOB: \_\_\_\_\_  
 \_\_\_\_\_ SS#: \_\_\_\_\_  
 \_\_\_\_\_

**Dependent information:**

Number of persons, including you, in household that is dependent upon stated income: \_\_\_\_\_

List of dependents other than patient:

Name:	SS#	DOB	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Financial History-Gross Income:**

Salary/Wages	Patient/Guarantor _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/>
	Spouse _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/>
Social Security/SSI	Patient/Guarantor _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/>
	Spouse _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/>
Public Assistance	Patient/Guarantor _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/>
	Spouse _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/>
Self Employment	Patient/Guarantor _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/>
	Spouse _____	Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/>
Child Support		Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/>
<b>TOTAL INCOME</b>	_____	

**Assets**

Bank Accounts:

Checking \_\_\_\_\_ (Spouse/Guar.) \_\_\_\_\_ Name of Bank: \_\_\_\_\_  
 Savings \_\_\_\_\_ (Spouse/Guar.) \_\_\_\_\_ Name of Bank: \_\_\_\_\_  
 Other \_\_\_\_\_ (Spouse/Guar.) \_\_\_\_\_ Name of Bank: \_\_\_\_\_

Vehicles: Year \_\_\_\_\_ Make \_\_\_\_\_ Stocks/Bonds \_\_\_\_\_  
 Year \_\_\_\_\_ Make \_\_\_\_\_

Home Value: \_\_\_\_\_ Mobile Home: \_\_\_\_\_ Land Value \_\_\_\_\_ Life Insurance/whole term \_\_\_\_\_

**TOTAL ASSETS TO INCLUDE AS INCOME:** \_\_\_\_\_

**Liabilities**

Rent \_\_\_ Mortgage \_\_\_ \_\_\_\_\_

Utilities:

Gas \_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

Electricity \_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

Water \_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

Telephone \_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

Groceries \_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

Charge Accts/Loans \_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

\_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

\_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

Vehicle Loan \_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

\_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

Medical Bills \_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

\_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

\_\_\_\_\_ Monthly \_\_\_ Quarterly \_\_\_ Bi-Yearly \_\_\_ Yearly \_\_\_

**Total Liabilities** \_\_\_\_\_

Other Third Party Coverage:

Insurance Company(s): \_\_\_\_\_ Subscriber # \_\_\_\_\_  
\_\_\_\_\_ Subscriber# \_\_\_\_\_

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND I AUTHORIZE THE VCU HEALTH SYSTEM TO VERIFY THIS INFORMATION BY CONTACTING EMPLOYERS OR OTHER AGENCIES AND BY CONDUCTING CREDIT CHECKS. I ALSO AGREE TO PROVIDE VERIFICATION OF MY ABOVE STATED FINANCIAL POSITION WITHIN THE REQUIRED DEADLINE IN ORDER TO BE CONSIDERED FOR ASSISTANCE. IF AT ANY TIME, I OBTAIN INSURANCE OR IF MY FINANCIAL SITUATION CHANGES, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY VCU HEALTH SYSTEM.

I AUTHORIZE VCUHS TO RELEASE MY FINANCIAL RECORDS (INCLUDING SOCIAL SECURITY NUMBER) TO PHARMACEUTICAL COMPANIES AND/OR THEIR AGENTS FOR DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE FOR MEDICATIONS.

Patient/Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient/Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_  
Interviewer/Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

<b>OFFICE USE ONLY</b> Referral for Patient/Family Members made to: Medicaid _____ SLH _____  Comments: _____ _____
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