VCU Health

Financial Counseling

Box 980138
Richmond, Virginia 23298-0138

(804) 828-0966
1-800-762-6161 Toll Free

Monday-Friday, 9 a.m. to 4 p.m.

Dear Patient, or Parent/Legal Guardian

VCU Health is proud of its mission to provide quality care to all who need it. If you do not have health insurance and worry that you may not be able to cover all of your medical costs, we may be able to help.

We provide financial assistance to patients based on their household income, number of dependents and assets. We can assist you with:

- Applying for hospital assistance
- Completing Medicaid applications
- Renewing your membership with Affordable Care Act (ACA) insurance plans

Also, we can arrange easy-to-manage payment options, help navigate Medicare assistance programs and explain your VCU Health bills. To be considered for financial assistance, please complete and sign the forms on the following pages, and mail them to:

VCU Health Financial Counseling
Box 980138
Richmond, Virginia 23286-0441

Or you can fax your completed paperwork to (804) 828-2029.

If you have any questions or would like more information, please call us at (804) 828-0966, Monday through Friday, 9 a.m. to 4 p.m.

Please note that until you have been approved to receive financial assistance, you are responsible for any balances due on medical bills, and copayments or deposits due at the time of service.

Thank you for choosing VCU Health as your health care provider.

Part 1: Financial Assistance Checklist

To be considered for financial assistance from VCU Health System, the following information must be provided:

1. A completed financial statement signed by the responsible party/parties.

2. Proof of income must be provided by all of the following that applies to you and/or your household:

- ❑ Copies of last three most recent pay stubs (must be consecutive)
- ❑ Copy of W-2 form (from previous year)
- ❑ Copy of recent welfare benefit letter (i.e TANF, General Relief)
- ❑ Copy of Social Security check or award letter (recent for this year)
- ❑ Verification of child support (i.e. court order, last three recent stubs, notarized letter from parent, last three recent bank statements showing consecutive payments)
- ❑ If no income, notarized letter from someone other than yourself or family member. Letter must explain how expenses are met. (If income is not reported by one of the above methods, please contact our Financial Counseling Call Center for assistance.)
- ❑ Schedule C and 1040 tax returns for self-employed (from previous year)
- ❑ Termination letter from last employer
- ❑ Recent bank statement ❑ Checking ❑ Savings ❑ Both
- ❑ Visa, passport (stamped I-551), green card (resident alien) or verification from immigration verifying made application for U.S. residency
- ❑ Recent retirement income verification
- ❑ Letter from employer (on company letterhead) verifying gross wages from last three pay periods, or verifying pay rate, number of hours worked weekly and how often paid.
- ❑ Other_____
- ❑ Other_____
- ❑ Other_____

If applicable, additional asset verification may be required.

Full Name _____ Medical Record Number _____

Part 2: Financial Statement

Patient Information

Full Name_____ Date of Birth_____

Medical Record Number_____ SSN _____

Martial Status _____ Citizen ❑ Yes ❑ No Virginia Resident ❑ Yes ❑ No

Street Address _____

Phone _____ Email _____

Employer* _____ Phone _____

Employer Address _____

Spouse and/or Guarantor Information

Full Name_____

Relationship ❑ Spouse ❑ Child ❑ Parent ❑ Other _____

Date of Birth _____ SSN _____

Phone _____ Email _____

Employer* _____ Phone _____

Employer Address _____

Dependent Information

Number of persons, including you, in household that is dependent upon stated income _____ . Please list dependents other than patient below:

Name	**SSN**	**DOB**	**Relationship**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Gross Income

Salary/Wages	Patient_____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
	Spouse _____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
Social Security/SSI	Patient_____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
	Spouse _____	❑ Weekly	❑ BiWeekly	❑ Monthly	❑ Yearly
Public Assistance	Patient_____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
	Spouse _____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
Self-Employment	Patient_____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
	Spouse _____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
Child Support	Patient_____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
	Spouse _____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly

Total Income _____

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*If self-employed, identify type of business

Assets

Bank Accounts:

Checking _____ Spouse _____ Name of Bank _____

Saving_____ Spouse _____ Name of Bank _____

Other _____ Spouse _____ Name of Bank _____

Vehicles:

Year_____ Make_____ Model _____

Year_____ Make_____ Model _____

Home Value_____ Mobile Home_____ Land Value _____

Life and/or Whole-term Insurance _____ Stocks and/or Bonds _____

Total Assets _____

Liabilities

Rent _____ Mortgage _____

Utilities:

Gas _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Electricity _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Water _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Telephone _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Groceries _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Charge Accounts and Loans:

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Vehicle Loans:

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Medical Bills

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Total Liabilities _____

Other Third Party Coverage:

Insurance Companies _____ Subscriber No. _____

_____ Subscriber No. _____

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 VCU Health System to release my financial records (including Social Security Number) to pharmaceutical companies and/or their agents for determining eligibility for financial assistance for medications and other assistance programs.

Patient Signature _____ Date _____

Spouse/Guarantor Signature _____ Date _____

Interviewed/Witnessed By_____ Date _____

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