

FINANCIAL APPLICATION					Account #					
Patient Name					Social Security #			Date of Birth		
Applicant Name (if minor, person responsible for patient)					Social Security #			Date of Birth		
Spouse Name					Social Security #			Date of Birth		
Street Address					City, State, Zip					
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					Home #		Work #		Alternate #	
Bank Name (where accounts are)					Checking Average Balance		Savings Average Balance			
LEGAL TAX DEPENDANTS (should match tax return)						TOTAL NUMBER (include yourself) →				
List Children		Age	List Children		Age	List Children		Age		
EMPLOYMENT										
	Employer Name			Employer Telephone	Occupation	Start Date	End Date	Hourly or Salary Amt.	Avg. Hrs. Per Wk.	Gross Wage Amount
Patient								\$		\$
Spouse								\$		\$
Applicant								\$		\$
If you are currently unemployed and receiving support from a family member, please have them provide you with a letter stating the type, dollar amount, and frequency of assistance they are providing.										
Date you became unemployed				Previous employer						
Name of person supporting you					Relationship					
Name of nearest living relative					Relationship					
Address, city, state, zip					Phone #					
OTHER INCOME AND ASSETS (fill in all that apply)										
Social Security Benefits			Social Service Programs				Assets			
<input type="checkbox"/> Disability	\$		TANF / General Relief	\$		Bonds/IRAs/Certificates	\$			
<input type="checkbox"/> Retirement	\$		VA Pension	\$		Interest Income	\$			
<input type="checkbox"/> SSI	\$		Unemployment	\$		Retirement	\$			
Other Disability	\$		Child Support / Alimony	\$		401K Mutual Funds	\$			
MONTHLY EXPENSES										
Mortgage	Payment Amount	\$	Loan Amount	\$	Assessment Value	\$	Auto Loan(s)	\$		\$
Rent	\$						Auto Year & Make			
Alimony/Support	\$						Auto Year & Make			
Credit Cards	Type				Payment Amount	\$	Loan Amount	\$	Assessment Value	\$
					\$		\$		\$	
					\$		\$		\$	

I authorize VCU Health Tappahannock Hospital to obtain such information as you may require concerning the statements contained herein and hereby certify that all statements are true and complete.

Signature of Applicant _____ Date _____

Please see back of form for a list of required documents to submit with your application.



PROOF OF INCOME

If you are financially unable to pay for your services, please complete the enclosed Financial Application and provide proof of income. VCU Health Tappahannock Hospital uses the Federal Poverty Income Guidelines to determine eligibility for financial assistance. Currently, a patient with income of 200% or less of the guidelines will be considered in addition to the other criteria.

The following items are required:

1. 3 months of bank statements
2. Copy of financial award letter *(if applicable)*
3. Copy of previous year tax return. If self-employed, a Schedule C is required.
If you do not provide a copy of the tax return, a signed 4506T verification of non-filing and request of transcript is required. This form can be obtained from the financial counselor or from the IRS at <http://www.irs.gov/pub/irs-pdf/f4506t.pdf>.
4. Copy of document(s) that explain the type, dollar amount, and frequency of assistance you are receiving *(if applicable)*
5. If employed, please provide 3 months of payroll stubs for both you and your spouse *(if applicable)*.
6. If unemployed *one year or less*, please provide a letter of termination from the employer.
If unemployed *more than one year*, please provide a document from Social Security, IRS, or Virginia Employment Commission reflected no earnings for a 12 month period.

If you are married, please include proof of income for your spouse.

The completion of this application will help us determine eligibility for assistance towards your hospital bills. Additional documentation may be requested when reviewing the application.

In the event that you have medical insurance that we are not aware of, please call our office immediately so we can file the claim for services to your insurance company. Please have your card available for us to see.

If you have questions or need assistance in filling out this application, please contact a VCU Health Tappahannock Hospital Representative at:

VCU Health Tappahannock Hospital
 608 Denbigh Boulevard, Suite 605
 Newport News, VA 23608
 757-989-8830, option #3 or 1-800-621-7677

FOR OFFICE USE ONLY				
Processed by _____			Date _____	Trans Code _____
Installment\$ _____ <input type="checkbox"/> HAC <input type="checkbox"/> IC Trust <input type="checkbox"/> Other _____			Family Size _____	Gross Family Income _____
Account #	DOS	Charges	Adjustment Amount	TOTAL ADJUSTMENT \$ _____
Comments _____				
Approval Signature _____			Date _____	