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____________________________________________________________
Medical Record Number________________________________SSN______________
Martial Status_________________________________________________________
Street Address________________________________________________________________________
Phone________________________________________________Email______________________
Employer*___________________________________________________________Phone__________________
Employer Address_____________________________________________________

**Spouse and/or Guarantor Information**

Full Name____________________________________________________________
Relationship □ Spouse □ Child □ Parent □ Other_____________________________
Date of Birth_________________________________________________________
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:

<table>
<thead>
<tr>
<th>Name</th>
<th>SSN</th>
<th>DOB</th>
<th>Relationship</th>
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<tbody>
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</tbody>
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**Gross Income**

<table>
<thead>
<tr>
<th>Source</th>
<th>Patient</th>
<th>□ Weekly □ Biweekly □ Monthly □ Yearly</th>
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</thead>
<tbody>
<tr>
<td>Salary/Wages</td>
<td></td>
<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Spouse</td>
<td></td>
<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Social Security/SSI</td>
<td></td>
<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Patient</td>
<td></td>
<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Spouse</td>
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<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Public Assistance</td>
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<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Patient</td>
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<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Spouse</td>
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<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Self-Employment</td>
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<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Patient</td>
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<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Spouse</td>
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<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Child Support</td>
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<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Patient</td>
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<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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<tr>
<td>Spouse</td>
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<td>□ Weekly □ Biweekly □ Monthly □ Yearly</td>
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</table>

**Total Income** __________________________
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 ________________