

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

MRN: _____

Patient Information

Full Name _____ Date of Birth _____

Street Address _____

Home phone _____ Employer Phone: _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated (timeframe) _____ ☐ Other SSN _____

Citizen ☐ Yes ☐ No Virginia Resident ☐ Yes ☐ No

Is this visit related to an accident or injury? ☐ Yes ☐ No Insurance Co Name and Subscriber No. _____

Household Members

Household Member Name	Relationship to Applicant Spouse, Child, Parent, Other	Date of Birth	Social Security Number	Citizen
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Income

Household Member Name	Income Type / Employer / Address Wages, Social Security, Child Support, Self-Employment, Other <i>*If self-employed, identify type of business</i>	Income Amount	Period Weekly, Bi-Weekly, Monthly, Yearly
Total Income		\$	

Assets

Asset Type Bank Accounts, Life Insurance Vehicles (include year, make, model) Real Estate including home	Asset Details Name of Bank, if applicable	Amount/Value	Period Weekly, Bi-Weekly, Monthly, Yearly
Total Assets		\$	

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 _____



VCUHealthTM