

## Application for Financial Assistance

Please enter the requested patient information. This will help us locate your account in our system. Enter your name on the Assistance Requested by line if you are not the patient. You will also need to add your relationship to the patient. The Write Off Amount is the balance on the account after all other resources have paid.

We need to get income details on you and your household members. Enter the name, age, relationship, gross monthly income, and income source of each household member. Gross monthly income is the amount before any taxes and deductions. The source of income is most often the member's job. In this case, write in the name of their employer. Income can also be from non-traditional or passive sources. Please provide the specific source of income for each member listed. All family members included on the patient's federal income tax return must be listed. Use additional sheets if more space is needed.

You are asked to provide information on your assets, liabilities, income, and living expenses. You will need to fill in the requested details about your housing costs and any vehicles you own. Your monthly living expense is the sum of all your bills including food, medical, utilities, housing, clothing, and transportation. Please check the box next to the expense amount category that reflects your monthly living expense. Do not send documentation of your bills unless requested to do so.

Total family income for the last three months is the sum of all gross monthly income from the household members you listed above, multiplied by three.

Please include the current balance of any checking, savings, investment or retirement accounts in the spaces indicated. If none exists, write "none".

What other resources do you have available to you? Please check all boxes next to the listed resources that are available to you. You can also check the other box and write in any resource not listed.

Was this service due to an accident? If yes, and you have an attorney representing you; please indicate this on the application. You'll need to provide us with the attorney's contact information.

Sentara may require proof of income to consider this application. Sending this proof of income with your application will help us process it for you. Proof of income could include the following:

- a) Three most recent pay check stubs
- b) The most recent filed federal income tax return with supporting schedules
- c) Two most recent bank and investment statements
- d) A letter of support if unemployed

Additional proof may be required based on your specific financial situation and circumstances.

By signing this application you certify that you have provided us with true and correct information. Unsigned and incomplete applications cannot be processed.

Your completed application may be returned to any hospital registration area. You may also mail the application to the financial assistance office at the hospital. Financial assistance office addresses can be found online at [www.Sentara.com/financialassistance](http://www.Sentara.com/financialassistance). This information is in the Financial Assistance Policy and in the Plain Language Summary.

If you need help completing this application you may contact the financial assistance office at the phone number listed on the front of your billing statement.



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