SENTARA®

Sentara Hospitals
sentara.com

Application for Financial Assistance

Patient Name: _____ Account #: _____

Patient Address: _____

Phone #: _____ Admit Date: _____ Discharge Date: _____

Total Charges: _____ Write Off Amount: _____

Assistance Requested by: _____ Relationship to Patient _____

List every member of the patient's household, including patient, ***as listed on the tax return.*** *Use additional sheets if necessary.*

NAME	AGE	RELATIONSHIP	GROSS MONTHLY INCOME	SOURCE OF INCOME

PLEASE COMPLETE THE FOLLOWING SECTION ON YOUR ASSETS, LIABILITIES, INCOME AND EXPENSES:

Do you own or rent your home? ☐ Own ☐ Rent Monthly rent/mortgage amount: $ _____
Amount remaining on mortgage: $_____

Do you own or lease your car? ☐ Own ☐ Lease Monthly car payment amount: $ _____
Remaining car loan balance: $ _____

How much is your monthly living expense? ☐ Less than $500 ☐ Between $500 and $1,000
☐ Between $1,000 and $2,000 ☐ More than $2,000

Total family income for the last three (3) months $ _____

Checking Account Balance $_____ Savings Account Balance $_____

Non-Retirement Investment $_____ Retirement Savings Balance $_____

PLEASE CHECK IF YOU RECEIVE OR HAVE ANY OF THE FOLLOWING ADDITIONAL RESOURCES:

☐ Commercial Insurance ☐ Veteran's ☐ Champus/Tricare ☐ Medicare ☐ Medicaid
☐ SNAP ☐ Food Stamps ☐ TANF ☐ COBRA ☐ Other, please specify: _____

Was this service due to an accident in which you may have a claim or be represented by an attorney? _____
If so, what is the attorney's name and contact information?_____

I certify that the above information is true and correct. I authorize Sentara Hospitals to verify this information with employers and other agencies. I also understand that this information is subject to review by Federal and/or State Agencies. I also understand that I am expected to make application to any other help, which may be available to me.

_____ _____

Signature Date Requested

Dear Sentara Patient,

As health care providers, we are concerned with the well being of our patients from first entry to the hospital through discharge and billing.

We understand that health care expenses are frequently unplanned and satisfying this financial obligation can seem overwhelming. This is especially true if you are not covered by health insurance.

If you think that you may be eligible for financial assistance or care at a reduced rate based on your income, please help us in evaluating your eligibility for assistance by completing this form and returning it to us.

You can also call us at (540) 564-5866, or toll-free at 1-888-389-1644. We look forward to assisting you.

SENTARA®

Your community, not-for-profit health partner

RMH

Sentara RMH Medical Center
Sentara RMH Business Office
532 South Main Street
Harrisonburg, Virginia 22801

Place Stamp Here

SENTARA®

Please moisten and seal this application with care to ensure that your information is secure and this form is completely closed using this strip.

Atención: si habla español, tiene a su disposición servicios lingüísticos gratuitos.
Llame al 844-809-6648.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
844-809-6648 번으로 전화해 주십시오.

注意：如果您讲中文普通话，则将为您提供免费的语言辅助服务。
请致电 844-809-6648。