CONFIDENTIAL FINANCIAL ASSISTANCE APPLICATION

***Form must be completed in its entirety in order to be processed for Financial Assistance**

Date: _____

Patient Name: _____Record #_____

Guarantor's Name: _____Phone #_____

Spouse's Name: _____

Address: _____ Zip Code: _____
Number & Street City State

PATIENT'S MEDICAL INSURANCE COMPANY (NAME AND ADDRESS):

_____

_____

_____

GUARANTOR INFORMATION:

SOCIAL SECURITY NUMBER:

_____

EMPLOYER'S NAME AND ADDRESS:

_____

EMPLOYER'S PHONE #:_____

HOURS WORKED PER WEEK:_____

SPOUSE'S INFORMATION:

EMPLOYER'S NAME AND ADDRESS:

_____

EMPLOYER'S PHONE NUMBER #:_____

HOURS WORKED PER WEEK: _____

FAMILY SIZE

_____ # Adults in household

_____ # Children in household

Family Members Name	Birth Date	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GROSS MONTHLY INCOME

$_____ Guarantor's Gross Income

$_____ Spouse's Gross Income

$_____ Self-Employment Income

$_____Social Security Income

$_____Unemployment

$_____Worker's Compensation

$_____Child Support

$_____Cash assistance from DSS

$_____Food Stamps

$_____Pension/Retirement

$_____Annuity, Dividends

$_____Interest

$_____Other-please describe below

_____

$_____ **TOTAL INCOME**

ASSETS

$_____Checking Account Balance

$_____Savings Account Balance

$_____Money Market Account

$_____Stocks/Bonds/Mutual Funds

$_____IRAs/Retirement Funds

$_____Trust Funds

$_____Real Estate (market value less first mortgage)

$_____ Other Assets (please specify)

$_____**TOTAL ASSETS**

I hereby request Children's Hospital of Richmond at VCU to make determination of my eligibility for financial aid through Family Participation Plan and/or payment plan for hospital charges. I understand that the information I submit concerning my family's income and size are subject to verification. I also understand that if the information given is found to be false, I will be liable for the total bill.

_____ _____

Signature of Responsible Party Date

In the space provided below, please describe your personal situation and your reasons for requesting assistance:

_____

_____

_____

_____

_____

_____

_____

You must return copies of the following documents with this application. Any application without signature and the necessary documentation will be denied:

DOCUMENTATION REQUIRED (check list)

____ Proof of income

____Copy of most recent tax return

____Last statement for checking, savings, stocks, bonds, annuity, etc.

____Copy of Medicaid Denial Letter

Please submit the completed application and all requested documentation to:

Attention: Patient Accounts
Children's Hospital of Richmond at VCU
2924 Brook Road
Richmond, Va. 23220-1298