Financial Assistance

Application Instructions & Required Documents

Please attach the following information to your financial profile and return to our office. Complete all the applicable fields before sending back to the hospital.

1. Two copies of your most recent pay stub(s) or a copy of your most recent income tax forms
2. Copy of lease (if applicable)
3. Copy of your recent bank statements
4. Amount of your family annual gross income
5. Number of dependents in your family excluding yourself

Please make sure to send all listed information and sign and date the application. Failure to do so will cause your application to automatically be denied.

Note: This application does not apply to any physician billing that you receive from their offices. If you need to contact Ms. Tibbs, please call **703.558.2492**.

Return application and supporting documents to:

Virginia Hospital Center Business Office
Attn.: Angie Tibbs
601 S. Carlin Springs Rd.
Arlington, VA 22204

Family Monthly Budget

Account #:_____

Patient Information

Name:_____

Marital Status: Single

Address: _____

Employer: _____

Occupation: _____

Total Annual Gross Income: _____

Spouse and/or Responsible Party Information

Name:_____

Marital Status: Single

Address:_____

Employer: _____

Occupation:_____

Total Annual Gross Income: _____

Total # of dependents in the household (including yourself): _____

Housing	Total Owed	Mos. Pay
Mortgage or rent		
Second mortgage or rent		
Phone		
Electricity		
Gas		
Water and sewer		
Cable		
Maintenance or repairs		
Subtotal		

Loans	Total Owed	Mos. Pay
Personal		
Student		
Credit card		
Credit card		
Credit card		
Other		
Subtotal		

Transportation		
Vehicle 1 payment		
Vehicle 2 payment		
Bus/Taxi fare		
Insurance		
Fuel		
Subtotal		

Insurance		
Home		
Health		
Car		
Life		
Subtotal		

Food		
Groceries		
Dining out		
Subtotal		

Savings Accounts

Checking account		
Retirement account		
Investment account		
College		
Other		
Subtotal		

I/we have examined this application and to the best of our knowledge believe it is true, correct and complete.

_____

Patient

_____

Responsible Party/Spouse

Applied for Medicaid ____Yes ____No

Case Worker Name: _____

Medicaid #: _____

Appointment Date: _____

Green Card: _____