SENTARA®

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 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

To Be Completed By Manager

Date received_____By_____Documents for income verification_____
☐ Approved for Charity ☐ Reduced Fee ☐ Denied Reason:_____
Date of Charity Care_____ Determination Pending_____ CS/PP_____

Required Information For Consideration of Financial Hardship Discount

In order to process your application, proof of income is required. If your request is for services prior to the current year, proof of income for that specific year is required. A list of acceptable documentation is listed below. A signature and identification card must be submitted along with your completed application in order to process.

- Valid drivers license or identification card
- Most recent IRS tax forms (1040 and/or W-2) (must be signed)
- Check stubs for the past 30 days for all qualifying persons employed in the home
- Proof of all other income received in the past 30 days
- Most recent bank statement
- Award or denial letter from Social Security/disability
- Unemployment letter / unemployment check stubs for the past 30 days
- Medicaid card, if applicable
- If no income, please provide a notarized letter from the person(s) who provide financial support for you

We will be unable to process your request without your signature, a picture identification card, proof of income, or an incomplete application.

Should you have any questions about the application or required documents, please call our central billing office at 757-252-2910 or toll free at 1-888-236-2263.

Please return all items (as applicable) on this checklist along with your completed application to the address or fax listed below:

Sentara Physician Billing Office
ATTENTION: Financial Assistance Dept.
863 Glenrock Road
Norfolk, VA 23502

*FAX# 757-452-3886

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。

ATTENTION: Language assistance services are available to you free of charge. Call 844-809-6648

Sentara Healthcare complies with applicable Federal Civil Rights Laws and does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, culture, color, religion, marital status, age, sex, sexual orientation, gender identity or gender expression, national origin or any disability or handicap.

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

Place Stamp Here

Sentara Physician Billing
Attention: Charity Coordinator
PO Box 179
Norfolk, VA 23502

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 757-252-2910 or Toll Free at 1-888-236-2263.

We look forward to assisting you.

APS, SDHMA, SMG, SMJMG, SRMG

www.sentara.com

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