SENTARA®

Hospitales Sentara
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申请财政资助
Application for Financial Assistance

患者姓名: ______________________ 帐户#: ______________
Patient Name *Account #*

患者住址: ______________________
Patient Address

电话号码#: ______________ 住院日期: ______________ 出院日期: ______________
Phone # *Admit Date* *Discharge Date*

收费总计: ______________________ 核销金额: ______________
Total Charges *Write Off Amount*

求助人: ______________________ 与患者的关系 ______________
Assistance Requested by: *Relationship to Patient*

像纳税申报表一样列出患者家庭的每一位成员，**包括患者**。 如有必要，使用附加表。
*List every member of the patient's household, including patient, **as listed on the tax return.** Use additional sheets if necessary.*

姓名 NAME	年龄 AGE	关系 RELATIONSHIP	月总收入 MONTHLY GROSS INCOME	收入来源 SOURCE OF INCOME

请就您的资产、负债、收入和支出填写下面的部分:
PLEASE COMPLETE THE FOLLOWING SECTION ON YOUR ASSETS, LIABILITIES, INCOME AND EXPENSES

您拥有还是租赁房子? ☐ 拥有 *Own* ☐ 租赁 *Rent* 月租金/房贷金额: $ ______________
Do you own or rent your home? *Monthly rent/mortgage amount*

剩余房贷金额: $ ______________
Amount remaining on mortgage

您拥有还是租赁车子? ☐ 拥有 *Own* ☐ 租赁 *Lease* 每月车贷支付金额: $ ______________
Do you own or lease your car? *Monthly car payment amount*

剩余车贷金额: $ ______________
Remaining car loan balance

您每月的生活费用有多少?
How much is your monthly living expense?

☐ 少于 500美元 ☐ 在500美元与1000美元之间
☐ 在1000美元与2000美元之间 ☐ 多于 2000美元
Less than $500 *Between $500 and $1,000*
Between $1,000 and $2,000 *More than $2,000*

前三（3）个月的家庭总收入 $ ______________
Total family income for the last three (3) months

支票账户余额 $ ______________ 储蓄账户余额 $ ______________
Checking Account Balance *Savings Account Balance*

非退休投资 $ ______________ 退休储蓄余额 $ ______________
Non-Retirement Investment *Retirement Savings Balance*

请检查您是否接受或有任何以下其他的资源:
PLEASE CHECK IF YOU RECEIVE OR HAVE ANY OF THE FOLLOWING ADDITIONAL RESOURCES

☐ 商业保险 *Commercial Insurance* ☐ 退伍军人保险 *Veteran's* ☐ Champus/Tricare ☐ Medicare ☐ Medicaid

☐ SNAP ☐食品券 *Food Stamps* ☐ TANF ☐ COBRA ☐ 其他，请注明: *Other, please specify* ______________

此服务是由于您可能有意外事故索赔，还是由于有代理律师? ______________
Was this service due to an accident in which you may have a claim or be represented by an attorney?

如果的确如此，律师的姓名和联系方式是什么? ______________
If so, what is the attorney's name and contact information?

我保证以上信息真实无误。我授权Sentara医院与我的雇主和其它机构核实这些信息。我也明白这些信息可能被联邦和/或国家机构审查。我也明白，我被希望对任何其他适合于我的帮助提出申请。
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.

______________________ ______________________
签字 *Signature* 申请日期 *Date Requested*

Place
Stamp
Here

Sentara Healthcare
ATTN: Financial Assistance Coordinator
535 Independence Parkway, Suite 700
Chesapeake, Virginia 23320

尊敬的 Sentara 患者

作为医疗保健机构，从入院、出院到发帐单，我们都关注我们患者的福利。

我们明白，医疗保健花费经常是不期而来，而偿付这种财务可能负担过重。尤其是如果您没有健康保险。

如果您认为您可能有资格申请财政资助，或根据您的收入您可能有资格获得低收费照护，请填写此表格并返回给我们，以帮助我们评估您是否有资格申请帮助。

您也可以拨打我们在Williamsburg的电话（757）233-4600或（757）984-4600。我们期待着助您一臂之力。

SENTARA®
您的社区，非营利的健康伙伴

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