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 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, gender expression, national origin, disability, or source of payment.

Please place in an envelope and mail your signed application with proof of income to:

Sentara Health
ATTN: Financial Assistance Coordinator
824 N. Military Hwy., #100
Norfolk, VA 23502

#2248 (6-24)

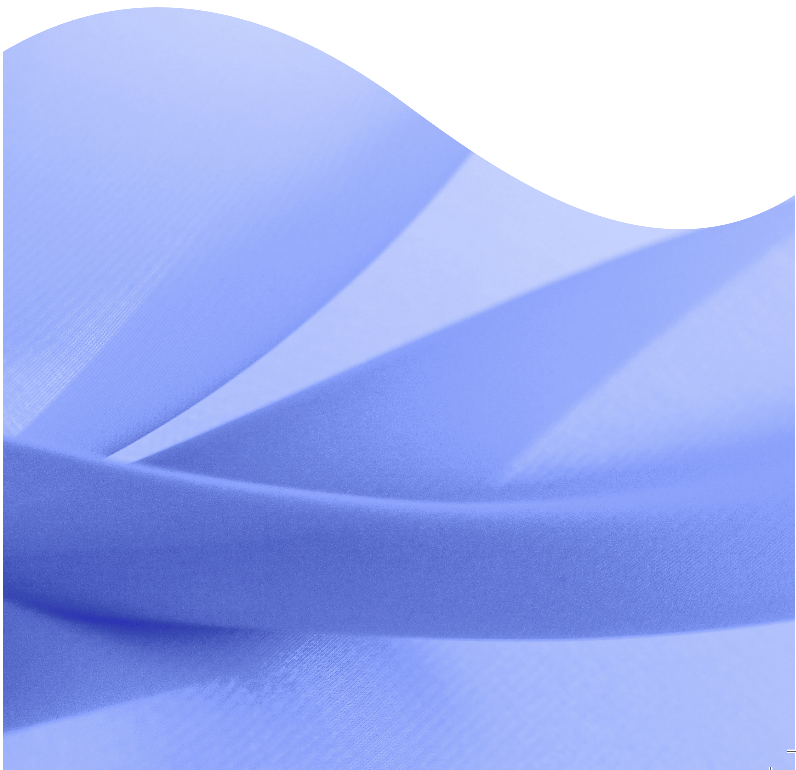
Dear Sentara Patient,

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) 233-4600. We look forward to assisting you.



Sentara Health
Application for Financial Assistance

Patient Name: ______________________ Account/Visit #: ____________

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 $ ____________

Are you or any child in your home eligible for Medicaid?

____

I certify that the above information is true and correct. I authorize Sentara Health 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