VIRGINIA UROLOGY

Financial Assistance Application

Received: ______________________________ Account Number: ______________________________

Expiration of Financial Assistance: ____________________ Approval Percentage: __________________________

<u>FINANCIAL ASSISTANCE DOES NOT APPLY TOWARD DRUGS AND SUPPLIES. FINANCIAL ASSISTANCE IS EFFECTIVE FOR 6 MONTHS FROM THE APPROVAL DATE OF THIS APPLICATION.</u>

<u>THE COMPLETED APPLICATION AND ALL DOCUMENTATION MUST BE RETURNED WITHIN 10 DAYS.</u>
<u>IF NOT RETURNED WITHIN THAT TIME, YOU WILL BE RESPONSIBLE FOR THE BALANCE OF THE ACCOUNT.</u>

If you have any questions concerning this Financial Assistance application, please contact our office at (804) 287-1030.

Office hours are Monday –Thursday 10 a.m. until 4 p.m. and Friday 8 a.m. until Noon.

<u>To process your application for financial assistance, please provide the following documentation:</u>

- Proof of income from **EVERYONE** living in the household (current pay stub that shows year to date salary, letters or notices for Social Security, Supplemental Security Income, Disability, unemployment compensation, Veteran's benefits, pensions, settlements, or **any** other type of income.)
- Previous year's tax returns.
- Complete copy of your two (2) most recent bank statements. Please be sure to include all pages. Incomplete bank statements will cause delay or denial of your financial application.
- Records of tips, bonuses, and commissions.
- Alimony or child support information.
- If you have **<u>NO</u>** income, you must have a **NOTARIZED** statement from the individual(s) providing financial support.

Patient Name: ____________________ Social Security Number: _____ -___ -_______ Phone: (____)__________ Marital Status: _____________

Address: ____ Date of Birth:______________________

Number of dependents (including yourself that can be claimed on your taxes): ________

Are you currently employed: (Circle one) **YES** **NO** (Circle One) **FULL TIME** **PART TIME**

*If **NO**, list dates of unemployment ____ **If PART TIME**, Hours per Week: _______________

Employer Name:____ Employer Phone: (_______) ____________________

<u>If patient is a dependent child, please list Parent/Guardian information below:</u>

Name: ____________________________________ Social Security number: _______ -_____ -________ Phone: (___)______________

Address:____ Relationship to Child: ________________

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List Primary Income (paycheck, Social Security, Supplemental Security Income, unemployment compensation, veteran's benefits, and pensions):

$______________Per Month

List Secondary Income (child support, alimony, settlements, or any other type of income):

$______________Per Month

TOTAL ANNUAL INCOME: $____________________

(This includes your income, spouse/companion income and all secondary income)

I hereby certify that the information provided is true and accurate to the best of my knowledge:

Signature:____ **Date:** ________________________

NOTE: If any information changes with regard to your employment, income, or insurance coverage, you must notify Virginia Urology IMMEDIATELY, or forfeit any discounts.

<u>Return form and documentation to one of Virginia Urology's seven convenient locations</u>