Financial Assistance Application

Received: ______________________________ Account Number: ____________________________

Expiration of Financial Assistance: ___________________ Approval Percentage: ________________________

FINANCIAL ASSISTANCE DOES NOT APPLY TOWARD DRUGS AND SUPPLIES. FINANCIAL ASSISTANCE IS EFFECTIVE FOR 12 MONTHS FROM THE APPROVAL DATE OF THIS APPLICATION.

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

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.

To process your application for financial assistance, please provide the following documentation:

- 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 **NO** 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: (_______) ____________________

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

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.

Return form and documentation to one of Virginia Urology's seven convenient locations

VU 1035

Revised:11/06; 4/08; 11/10; 5/12; 8/17; 7/18