



APPLICATION FOR FINANCIAL ASSISTANCE

PLEASE MAIL COMPLETED FORM TO: ATTENTION
VERIFICATION DEPARTMENT
BOX 800750
CHARLOTTESVILLE, VA 22908-0750

Toll Free 1 866 320 9659
Local (434) 924 8718

STEP 1: COMPLETE INFORMATION BELOW: (ALL QUESTIONS *MUST* BE ANSWERED)

PATIENT NAME:	SOCIAL SECURITY NO:
ADDRESS:	BIRTH DATE:
CITY, STATE, ZIP:	MEDICAL RECORD NO:
MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED SEPARATED WIDOWED	

STEP 2: FILL OUT INCOME/ASSET INFORMATION: IF ADDITIONAL SPACE IS REQUIRED PLEASE ATTACH SEPARATE PIECE OF PAPER.

FAMILY MEMBERS – INCLUDE SELF, SPOUSE CHILDREN UNDER 18	SOCIAL SECURITY NO:	DATE OF BIRTH	RELATION TO PATIENT	MONTHLY GROSS WAGES/ SOCIAL SECURITY, ETC.	EMPLOYER NAME	EMPLOYER PHONE NO.

IF UNEMPLOYED, PROVIDE THE DATE EMPLOYMENT ENDED _____. HAVE YOU APPLIED FOR UNEMPLOYMENT? **YES / NO**
 IF THERE IS NO REPORTED INCOME, HAVE YOU APPLIED FOR DISABILITY? **YES / NO** ARE YOU PLANNING ON APPLYING? **YES / NO**
 DOES ANYONE IN YOUR HOUSEHOLD RECEIVE ANY OF THE FOLLOWING TYPES OF ASSISTANCE (PLEASE PROVIDE PROOF OF BENEFITS RECEIVED)?
 MEDICAID / SLH **YES / NO** HOUSING (SECTION 8 / HUD) **YES / NO** FOOD STAMPS: **YES / NO** AMOUNT \$ _____
 CHILD SUPPORT/TANF **YES / NO** AMOUNT \$ _____ GENERAL RELIEF: **YES / NO** AMOUNT \$ _____ ALIMONY: **YES / NO** AMOUNT \$ _____

CHECKING ACCOUNT NO: YES / NO (CIRCLE)	BANK NAME: LOCATION:	BALANCE: \$
SAVINGS ACCOUNT NO: YES / NO (CIRCLE)	BANK NAME: LOCATION:	BALANCE: \$
STOCKS, BONDS, IRA'S, 401K, CDs, ETC. YES / NO (CIRCLE)	BANK NAME: LOCATION:	BALANCE: \$

REAL ESTATE PROPERTY: **YES / NO** CITY/COUNTY: _____ **RENT / BUY** TOTAL ACREAGE: _____ MONTHLY PAYMENT \$ _____

DO YOU HAVE LIFE INSURANCE FOR YOU OR ANY DEPENDENT OVER 21 WITH A CASH OR LOAN VALUE? YES / NO (CIRCLE)		
NAME OF INSURANCE CO:	POLICY NO:	CASH-IN VALUE: \$

PERSONAL PROPERTY: **YES / NO** (CIRCLE ONE) LIST ALL CARS, BOATS, TRUCKS, MOTORCYCLES, CAMPERS, MOBILE HOMES, ETC.

ITEM:	MAKE MODEL	YEAR:	OWNER:	AMOUNT OWED: \$	VALUE: \$

DECLARATION: THE INFORMATION PROVIDED ABOVE IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, COMPLETE, ACCURATE AND TRUE. I AUTHORIZE THE RELEASE OF ALL INFORMATION WHICH THE UVA MEDICAL CENTER MAY NEED TO DETERMINE WHETHER I QUALIFY FOR FINANCIAL ASSISTANCE THROUGH THE HOSPITAL'S INDIGENT CARE PROGRAM, ANY DRUG MANUFACTURER SPONSORED DRUG ASSISTANCE PROGRAM OR ANY OTHER FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, INCLUDING VERIFICATION OF MY SALARY OR WAGES, THE BALANCE OF ANY BANK ACCOUNTS THAT I MAINTAIN, THE CASH-IN VALUE OF ANY LIFE INS. POLICY, STOCKS OR BONDS WHICH I POSSESS, AS WELL AS THE VALUE OF ANY REAL OR PERSONAL PROPERTY WHICH I OWN OR AM PURCHASING. SHOULD I BE REFERRED TO A FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM I AUTHORIZE THE UVA MEDICAL CENTER TO RELEASE AND OBTAIN ALL INFORMATION NEEDED TO DETERMINE ELIGIBILITY FOR THAT FUNDING.

SIGNATURE REQUIRED

APPLICANT'S SIGNATURE:	DATE:
SPOUSE'S SIGNATURE:	DATE: