RIVERSIDE
Health System

# FINANCIAL APPLICATION

Account #

| | | |
|---|---|---|
| Patient Name | Social Security # | Date of Birth |
| Applicant Name (if minor, person responsible for patient) | Social Security # | Date of Birth |
| Spouse Name | Social Security # | Date of Birth |
| Street Address | City, State, Zip | |
| Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | Home # / Work # / Alternate # | |
| Bank Name (where accounts are) | Checking Average Balance | Savings Average Balance |

**LEGAL TAX DEPENDANTS** ***(should match tax return)*** **TOTAL NUMBER** ***(include yourself)*** →

| List Children | Age | List Children | Age | List Children | Age |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**EMPLOYMENT**

| | Employer Name | Employer Telephone | Occupation | Start Date | End Date | Hourly or Salary Amt. | Avg. Hrs. Per Wk. | Gross Wage Amount |
|---|---|---|---|---|---|---|---|---|
| Patient | | | | | | $ | | $ |
| Spouse | | | | | | $ | | $ |
| Applicant | | | | | | $ | | $ |

**If you are currently unemployed and receiving support from a family member, please have them provide you with a letter stating the type, dollar amount, and frequency of assistance they are providing.**

| | |
|---|---|
| Date you became unemployed | Previous employer |
| Name of person supporting you | Relationship |
| Name of nearest living relative | Relationship |
| Address, city, state, zip | Phone # |

**OTHER INCOME AND ASSETS** ***(fill in all that apply)***

| Social Security Benefits | | Social Service Programs | | Assets | |
|---|---|---|---|---|---|
| ☐ Disability | $ | TANF / General Relief | $ | Bonds/IRAs/Certificates | $ |
| ☐ Retirement | $ | VA Pension | $ | Interest Income | $ |
| ☐ SSI | $ | Unemployment | $ | Retirement | $ |
| Other Disability | $ | Child Support / Alimony | $ | 401K Mutual Funds | $ |

**MONTHLY EXPENSES**

| | Payment Amount | Loan Amount | Assessment Value | | | |
|---|---|---|---|---|---|---|
| Mortgage | $ | $ | $ | Auto Loan(s) | $ | $ |
| Rent | $ | | | Auto Year & Make | | |
| Alimony/Support | $ | | | Auto Year & Make | | |

| Credit Cards | Type | Payment Amount | Loan Amount | Assessment Value |
|---|---|---|---|---|
| | | $ | $ | $ |
| | | $ | $ | $ |

I authorize Riverside Health System to obtain such information as you may require concerning the statements contained herein and hereby certify that all statements are true and complete.

Signature of Applicant _____ Date _____

****Please see back of form for a list of required documents to submit with your application.****

## PROOF OF INCOME

If you are financially unable to pay for your services, please complete the enclosed Financial Application and provide proof of income. Riverside uses the Federal Poverty Income Guidelines to determine eligibility for financial assistance. Currently, a patient with income of 200% or less of the guidelines will be considered in addition to the other criteria.

The following items are required:

1. 3 months of bank statements
2. Copy of financial award letter *(if applicable)*
3. Copy of previous year tax return. If self-employed, a Schedule C is required.
   If you do not provide a copy of the tax return, a signed 4506T verification of non-filing and request of transcript is required. This form can be obtained from the financial counselor or from the IRS at http://www.irs.gov/pub/irs-pdf/f4506t.pdf.
4. Copy of document(s) that explain the type, dollar amount, and frequency of assistance you are receiving *(if applicable)*
5. If employed, please provide 3 months of payroll stubs for both you and your spouse *(if applicable)*.
6. If unemployed *one year or less*, please provide a letter of termination from the employer.
   If unemployed *more than one year*, please provide a document from Social Security, IRS, or Virginia Employment Commission reflected no earnings for a 12 month period.

**If you are married, please include proof of income for your spouse.**

The completion of this application will help us determine eligibility for assistance towards your hospital bills. Additional documentation may be requested when reviewing the application.

In the event that you have medical insurance that we are not aware of, please call our office immediately so we can file the claim for services to your insurance company. Please have your card available for us to see.

If you have questions or need assistance in filling out this application, please contact a Riverside Representative at:

**Riverside Health System**
608 Denbigh Boulevard, Suite 605
Newport News, VA 23608
**757-989-8830, option #3 or 1-800-621-7677**

**FOR OFFICE USE ONLY**

| Processed by | Date | Trans Code |
|---|---|---|
| Installment$_____ ☐ HAC ☐ IC Trust ☐ Other _____ | Family Size | Gross Family Income |

| Account # | DOS | Charges | Adjustment Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

TOTAL ADJUSTMENT
$ _____

Comments

Approval Signature Date