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