SENTARA®

Sentara Medical Group
sentara.com

# Application for Financial Assistance

Patient Name: _____ Account #: _____

Patient Address: _____

Phone #: _____ Admit Date: _____ Discharge Date: _____

Total Charges: _____ Write Off Amount: _____

Assistance Requested by: _____ Relationship to Patient _____

*List every member of the patient's household, including patient,* ***as listed on the tax return.*** *Use additional sheets if necessary.*

| NAME | AGE | RELATIONSHIP | GROSS MONTHLY INCOME | SOURCE OF INCOME |
|---|---|---|---|---|
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**PLEASE COMPLETE THE FOLLOWING SECTION ON YOUR ASSETS, LIABILITIES, INCOME AND EXPENSES:**

Do you own or rent your home? ☐ Own ☐ Rent Monthly rent/mortgage amount: $ _____
Amount remaining on mortgage: $ _____

Do you own or lease your car? ☐ Own ☐ Lease Monthly car payment amount: $ _____
Remaining car loan balance: $ _____

How much is your monthly living expense? ☐ Less than $500 ☐ Between $500 and $1,000
☐ Between $1,000 and $2,000 ☐ More than $2,000

Total family income for the last three (3) months $ _____

Checking Account Balance $_____ Savings Account Balance $_____

Non-Retirement Investment $_____ Retirement Savings Balance $_____

**PLEASE CHECK IF YOU RECEIVE OR HAVE ANY OF THE FOLLOWING ADDITIONAL RESOURCES:**

☐ Commercial Insurance ☐ Veteran's ☐ Champus/Tricare ☐ Medicare ☐ Medicaid
☐ SNAP ☐ Food Stamps ☐ TANF ☐ COBRA ☐ Other, please specify: _____

Was this service due to an accident in which you may have a claim or be represented by an attorney? _____
If so, what is the attorney's name and contact information? _____

I certify that the above information is true and correct. I authorize Sentara Medical Group to verify this information with employers and other agencies. I also understand that this information is subject to review by Federal and/or State Agencies. I also understand that I am expected to make application to any other help, which may be available to me.

Signature _____ Date Requested _____

**To Be Completed By Manager**

Date received _____ By _____ Documents for income verification _____

☐ Approved for Charity ☐ Reduced Fee ☐ Denied Reason: _____

Date of Charity Care _____ Determination Pending _____ CS/PP _____ Revised 11/15

Place Stamp Here

Sentara Medical Group
ATTN: Charity Coordinator
**PO Box 179**
**Norfolk, Virginia 23501**

SENTARA®

Dear Sentara Patient,

As health care providers, we are concerned with the well being of our patients from first entry to the hospital through discharge and billing.

We understand that health care expenses are frequently unplanned and satisfying this financial obligation can seem overwhelming. This is especially true if you are not covered by health insurance.

If you think that you may be eligible for financial assistance or care at a reduced rate based on your income, please help us in evaluating your eligibility for assistance by completing this form and returning it to us.

You can also call us at (757) 252-2900 or Toll Free 1 (888) 236-2263.
We look forward to assisting you.

SENTARA®

*Your community, not-for-profit health partner*