SENTARA

Virginia Beach Ambulatory Surgery Center
www.vbasc.com

Financial Assistance Eligibility Determination

Patient Name:____ **Account #:** ________________
Patient Address:
Phone #:____ **Date of Service:**
Total Charges: _____________________________ **Balance Due:** ________________________________
Financial 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	Employer Address & Phone #

Total number in household: **Do you own your home?** ☐ **Yes** ☐ **No**
Do you rent? ☐ **Yes** ☐ **No**

Other Sources of Income **Gross Amount Per Month**

Last 3 Months
Total Family Income _ **X 4 = 12 Months Total** _**Annual Gross Income**

Submit this application with copies of the last two years' income tax filings as proof of family income.

Please complete the following:

Checking Account $________________________ **Savings Account $**
IRA **Retirement Savings**
401K/403B **Thrift Plan** **Mortgage Y or N**

** If you have any lab work that could be related to this service, you will need to contact the number listed on the bill you receive and inform them you have applied for assistance with the Sentara Business Office.

CHECK ANY OF THE FOLLOWING MEDICAL FINANCIAL RESOURCES THAT YOU HAVE:

☐Commercial Insurance ☐Veteran's ☐Champus/Tricare ☐Medicare ☐Medicaid
☐State & Local Hospital ☐Public Health Service

- 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? ______________________________________
  - If you have questions, please contact the Billing department at (757) 496- 6400 #2
  - I certify that the above information is true and correct. I authorize Sentara Hospitals 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 verif.
Approved for Charity Reduced Fee Denied Reason:
Date of Charity Care Determination pending CS/PP________________ Revised 10-02-13