Mary Washington Healthcare

PLEASE MAIL COMPLETED FORM TO:
MARY WASHINGTON HOSPITAL
ATTN: FINANCIAL COUNSELING
1001 SAM PERRY BOULEVARD
FREDERICKSBURG VA 22401

If you have questions please call
(855) 330-4857 or (540) 741-1041

APPLICATION FOR FINANCIAL ASSISTANCE

Complete Information Below: **(All Questions MUST be answered)**

PATIENT NAME:	SOCIAL SECURITY NO:
STREET ADDRESS:	BIRTH DATE: PHONE NUMBER:
CITY, STATE, ZIP:	MEDICAL RECORD NO:
MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED SEPARATED WIDOWED	
U.S. CITIZEN: □ YES □ NO VIRGINIA RESIDENT? □ YES □ NO	
Is the visit related to: Motor Vehicle Accident □ YES □ NO Work Injury □ YES □ NO Result of a Crime? □ YES □ NO (Denial from all third party liabilities will need to be provided before your application can be reviewed.)	

PART I Household Information:

HOUSEHOLD FAMILY MEMBERS – INCLUDE SELF, SPOUSE, CHILDREN UNDER 18	SOCIAL SECURITY NO	DATE OF BIRTH	RELATION TO PATIENT	ALL EMPLOYERS FOR CURRENT YEAR & EMPLOYMENT DATES (IF STUDENT, LIST SCHOOL & ATTENDANCE DATES)	EMPLOYER PHONE NO.

CONTINUE TO NEXT PAGE

PART II Presumptive Eligibility:
DOES ANYONE IN PART I RECEIVE ANY OF THE FOLLOWING ASSISTANCE? If so you may qualify under our presumptive eligibility clause. PLEASE CHECK ALL THAT APPLY AND ATTACH COPY OF AWARD LETTER. If you check any of the following, please skip to part VII.

□ Free/Reduced School Lunch
□ Food Stamps/SNAP
□ General Relief
□ Housing Assistance (Section 8/HUD)
□ Homeless Shelter/Clinic
□ Patient of: Moss Free Clinic, Guadalupe Clinic, Fredericksburg Christian Health Center or Community Health Center
□ TANF
□ WIC

PART III Family Income
List the amount of your household family monthly income from ALL sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social Security benefits	_____
Disability benefits	_____
Unemployment	_____
Veterans benefits	_____
Alimony or Child Support	_____
Rental property income	_____
Strike benefits	_____
Educational Assistance for living expenses	_____
Military allotment	_____
Farm or self- employment	_____
Other income source	_____
Total	_____

*IF UNEMPLOYED, PROVIDE THE DATE EMPLOYMENT ENDED _____. HAVE YOU APPLIED FOR UNEMPLOYMENT? **YES / NO**

If no income listed, how are you paying your expenses? Please provide proof.

_____
_____
_____
_____
_____
_____
_____

PART IV Liquid Assets
Please include bank name. Bank Name/Current Balance

Checking account(s): _____

Savings account (s): _____

Stocks, bonds, CD, or money market: _____

Other: _____

TOTAL: _____

PART V Other Assets
If you own any of the following items, please list the type and approximate value.

Real Estate: Yes/No

Address:	Residency Status	Fair Market Value:	Amount Owed:
	□ Buying □ Own		
	□ Buying □ Own		
	□ Buying □ Own		

Personal Property: Yes/No LIST ALL CARS, BOATS, TRUCKS, MOTORCYCLES, CAMPERS, MOBILE HOMES, ETC.

Item:	Make Model	Year:	Amount Owed: $	Value: $

PART VI Monthly Expenses

	Monthly Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Health or life insurance	_____
Auto/homeowners/renters insurance	_____
Childcare	_____
Child Support or Alimony	_____
Food	_____
Gas	_____
Other medical expenses (medicine, etc.)	_____
Other:	_____
	_____
Total	_____

PART VII Insurance Eligibility
Please circle the correct answer for each statement below

My employer DOES NOT offer health insurance coverage	YES	NO
I am NOT eligible for health insurance coverage through my or my spouse's employment	YES	NO
I have been screened ineligible or denied Medicaid	YES	NO

If you answered NO to any of the above statements, please explain why:

_____

_____

_____

PART VIII Authorization
DECLARATION: THE INFORMATION PROVIDED ABOVE IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, COMPLETE, ACCURATE AND TRUE. IF IT IS DETERMINED AT ANY TIME THAT THE INFORMATION I PROVIDED IS FALSE OR INACCURATE, ALL FINANCIAL ASSISTANCE WILL BE REVERSED, AND I WILL ACCEPT RESPONSIBILITY FOR FULL AND IMMEDIATE PAYMENT OF ANY AND ALL OUTSTANDING BALANCES. I ALSO AGREE TO ACCEPT PAYMENT RESPONSIBILITY FOR ANY AMOUNT DUE AFTER ANY PARTIAL FINANCIAL ASSISTANCE DISCOUNTS ARE APPLED.

I AUTHORIZE THE RELEASE OF ALL INFORMATION WHICH MWHC MAY NEED TO DETERMINE WHETHER I QUALIFY FOR FINANCIAL ASSISTANCE THROUGH THE MWHC FINANCIAL ASSISTANCE POLICY, ANY DRUG MANUFACTURER SPONSORED DRUG ASSISTANCE PROGRAM OR ANY OTHER FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, INCLUDING OBTAINING A CREDIT BUREAU REPORT, VERIFICATION OF MY SALARY OR EMPLOYMENT, 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.

I GIVE PERMISSION TO THE DEPARTMENT OF SOCIAL SERVICES TO PROVIDE BENEFITS INFORMATION REQUIRED TO EVALUATE MY ELIGIBILITY FOR FINANCIAL ASSISTANCE AT MWHC. SHOULD I BE REFERRED TO A FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM I AUTHORIZE MWHC TO RELEASE AND OBTAIN ALL INFORMATION NEEDED TO DETERMINE ELIGIBILITY FOR THAT FUNDING.

SIGNATURE REQUIRED

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

The following Physician Groups and their Providers have agreed to provide the same level of financial assistance to patients when the patient meets the MWHC financial assistance criteria for their hospital bill. Patients will need to contact the respective Physician Group and provide a copy of the MWHC Financial Assistance approval letter.

- American Anesthesiology Associates of Virginia Phone 1-888-280-9533
- Fredericksburg Emergency Medical Alliance 1-866-898-7138
- Sound Physicians 1-844-222-5808
- Pathology Associates of Fredericksburg 1-800-849-8085
- Radiology Associates of Fredericksburg 1-866-953-5869