APPLICATION FOR FINANCIAL ASSISTANCE

UVAHealth

https://uvahealth.com/services/billing-insurance/financial-assistance-information

PLEASE MAIL COMPLETED FORM TO:
ATTENTION VERIFICATION DEPARTMENT
BOX 800750
CHARLOTTESVILLE, VA 22908-0750
1-866-320-9659 (P) 1-434-924-9322 (F)
Email: Financialassistance@virginia.edu

STEP 1: COMPLETE INFORMATION BELOW:

PATIENT NAME:	SOCIAL SECURITY# (if applicable):
ADDRESS:	BIRTH DATE:
CITY, STATE, ZIP:	MEDICAL RECORD NO:
HOME TELEPHONE NUMBER:	WORK TELEPHONE NUMBER:
MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED SEPARATED WIDOWED	
ARE YOU A U.S. CITIZEN OR U.S. NATIONAL: † **YES / NO**	
†This information is necessary to determine eligibility for additional benefits/programs.	
IF YOU ARE NOT A U.S. CITIZEN OR U.S. NATIONAL, DO YOU HAVE ONE OF THE IMMIGRATION STATUSES LISTED BELOW? **YES /NO***	
*IF YOU ANSWERED 'NO', SKIP TO STEP 2 (you may still be eligible for assistance). IF YOU ANSWERED 'YES', INDICATE WHICH OF THE FOLLOWING DESCRIBES YOUR STATUS:	
☐ ASYLEE ☐ REFUGEE ☐ SPECIAL IMMIGRANT JUVENILE STATUS (SIJ) ☐ LEGAL PERMANENT RESIDENT WITH AT LEAST FIVE YEARS OF VA RESIDENCY ☐ RESIDENT OF U.S. SINCE 1996 ☐ VETERAN/ACTIVE U.S. MILITARY/SPOUSE OR PARENT OF VETERAN/ACTIVE U.S. MILITARY	

STEP 2: PLEASE COMPLETE THE FOLLOWING SECTIONS ON INCOME AND HEALTH CARE COVERAGE.
If additional space is needed, please attach a separate piece of paper.

FAMILY MEMBERS - INCLUDE SELF, SPOUSE, CHILDREN UNDER 18	SEX M/F	SOCIAL SECURITY # (if known)	BIRTH DATE	RELATION TO PATIENT	MONTHLY GROSS INCOME (see page 2)	EMPLOYER NAME	EMPLOYER PHONE NO.
				Self			

DO YOU RECEIVE THE FOLLOWING: CHILD SUPPORT **YES / NO** AMOUNT $_____ ALIMONY: **YES / NO** AMOUNT $_____
DO YOU HAVE MEDICARE OR ANY OTHER HEALTH INSURANCE WHICH COVERS ALL OR PART OF THE COST OF YOUR PRESCRIPTION MEDICATIONS? **YES/NO** IF YES, LIST THE INSURANCE NAME BELOW WITH THE MEMBER ID# AND GROUP #:

INSURANCE NAME	MEMBER ID#	GROUP#

STEP 3: PLEASE COMPLETE THE FOLLOWING SECTIONS ON RESOURCES.
If additional space is needed, please attach a separate piece of paper.

CHECKING ACCOUNT NO: **YES / NO**	BANK NAME:	BALANCE: $
SAVINGS ACCOUNT NO: **YES / NO**	BANK NAME:	BALANCE: $
STOCKS, BONDS, IRA'S, 401K, CDs, ETC. **YES / NO**	BANK NAME:	BALANCE: $

DO YOU OWN OR ARE YOU CURRENTLY BUYING REAL ESTATE PROPERTY: **YES / NO** CITY/COUNTY: _____TOTAL ACREAGE: _____
MORTGAGE AMOUNT: $_____ DO YOU LIVE ON THE REAL ESTATE PROPERTY: **YES / NO**
DO YOU HAVE LIFE INSURANCE FOR YOU OR ANY DEPENDENT OVER 21 WITH A CASH VALUE OR LOAN VALUE? **YES/NO**
IF YES, LIST THE INSURANCE(S) NAMES, POLICY NUMBER AND CASH VALUE: _____
PERSONAL PROPERTY: **YES / NO** LIST ALL CARS, TRUCKS, MOTORCYCLES, CAMPERS, MOBILE HOMES, ETC.
IF APPLICABLE; DO YOU RESIDE IN YOUR MOBILE HOME: **YES / NO**

ITEM:	MAKE MODEL	YEAR:	AMOUNT OWED: $	VALUE: $
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DECLARATION: THE INFORMATION PROVIDED ABOVE IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, COMPLETE, ACCURATE AND TRUE. I AUTHORIZE THE RELEASE OF ALL INFORMATION WHICH THE UVA HEALTH MAY NEED TO DETERMINE WHETHER I QUALIFY FOR FINANCIAL ASSISTANCE THROUGH THE HOSPITAL'S INDIGENT CARE PROGRAM, ANY DRUG MANUFACTURER SPONSORED DRUG ASSISTANCE PROGRAM OR ANY OTHER FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, INCLUDING VERIFICATION OF MY SALARY OR WAGES, 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. SHOULD I BE REFERRED TO A FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM I AUTHORIZE THE UVA HEALTH TO RELEASE AND OBTAIN ALL INFORMATION NEEDED TO DETERMINE ELIGIBILITY FOR THAT FUNDING. I AGREE TO IMMEDIATELY NOTIFY UVA WHEN MY INSURANCE (MEDICAL OR PRESCRIPTION) AND/OR INCOME CHANGES.

APPLICANT/GUARANTOR SIGNATURE (REQUIRED):	DATE:
SPOUSE'S SIGNATURE:	DATE:

This application was received by UVAHealth Employee: _____

Revised 10/20

The information and supporting documentation that is being requested is all required in order for our process to comply with the rules set by the Commonwealth for this program and in order to determine what other programs or assistance might be available to you.

Need Assistance Completing your application?

By Phone: 866-320-9659

By Email: Financialassistance@virginia.edu

By Fax: 434-924-9322

In Person: Education Resource Center (located next to the pharmacy)

1220 Lee St

Charlottesville VA 22903

Hours: M-F 8AM-5:00PM

APPLICATION FOR ASSISTANCE FORM INSTRUCTIONS

STEP 1: Please fill out all information concerning the patient completely.

STEP 2: Fill out income and healthcare coverage information. This includes income from your employer, government aid (social security, VA benefits), retirement, alimony, self-employment, or any other source of income. **If any child is 18 years or older, a separate form is required and cannot be included on this application**. A non-family member should not be included on this application unless the member is a child under the age of 18 with proof of custody.

STEP 3: Fill out the information about resources.

IN ORDER FOR UVA HEALTH TO COMPLY WITH STATE GUIDELINES, EACH OF THE ITEMS LISTED ON THE FRONT OF THIS APPLICATION WILL REQUIRE PROOF OR DOCUMENTATION. PLEASE DO NOT SEND IN YOUR APPLICATION UNLESS YOU HAVE ATTACHED ALL DOCUMENTATION NEEDED. ALL INFORMATION SHOULD BE RETURNED AS SOON AS POSSIBLE TO AVOID DELAYS.