1701 N. George Mason Drive
Arlington, VA 22205-3698
703.558.5000 tel
www.virginiahospitalcenter.com

Financial Assistance Application Instructions & Required Documents

Please attach the following information to your Financial Assistance Application and return it to our office. Complete all sections of the form before sending it back to the Hospital. Please include:

1. Two copies of your most recent pay stub(s) or a copy of your most recent income tax form (not more than 18 months old)
2. Copy of lease (if applicable)
3. Copy of your recent bank statements
4. Amount of your family annual gross income
5. Number of dependents in your family including yourself

Please make sure to send all listed information and the signed and dated application. Failure to do so will cause your application to be denied.

Note: This application does not apply to any non-Virginia Hospital Center Health System Physicians.

If you have any questions, please call 703-558-2492 or the Business Office at 703-558-6391.

Return your application and supporting documents to:

Virginia Hospital Center Business Office
2800 Shirlington Road
Suite 600
Arlington, VA 22206
Attn: Financial Assistance

OR:
Fax to 703-558-5774
Attn: Financial Assistance

Financial Assistance Application

Account #: ______________________

Patient Information	
Name:	
Marital Status:	
Address:	
Employer:	
Occupation:	
Total Annual Income:	

Spouse or Responsible Party Information	
Name:	
Marital Status:	
Address:	
Employer:	
Occupation:	
Total Annual Income:	

Total # of Dependents (including yourself): ______________________

Housing	**Total Owed**	**Monthly Pmt**
Mortgage or Rent		
2nd Mortgage		
Phone		
Electricity		
Gas		
Water/Sewer		
Cable		
Maintenance/Repairs		
Subtotal		

Loans	**Total Owed**	**Monthly Pmt**
Personal		
Student		
Credit Card		
Credit Card		
Credit Card		
Other		
Other		
Other		
Subtotal		

Transportation	**Monthly Pmt**
Vehicle 1 Payment	
Vehicle 2 Payment	
Bus/Taxi Fare	
Fuel	
Subtotal	

Bank Accounts	**Monthly Pmt**
Checking	
Savings	
Investment	
Other	
Subtotal	

Other Insurance	**Monthly Pmt**
Health	
Life	
Auto	
Home/Apt	
Subtotal	

Food	**Monthly Pmt**
Groceries	
Dining Out	
Subtotal	

I/we have examined this application and to the best of our knowledge believe that it is true, correct and complete.

Patient

Responsible Party/Spouse

Applied for Medicaid: Yes No

Case Worker Name: ______________________

Appointment Date: ______________________

Medicaid #: ______________________

Green Card: ______________________