

**VCU HEALTH SYSTEM
FINANCIAL STATEMENT**

Patient Information:

Name: _____ DOB: _____ MR# _____
 SS#: _____ Marital Status _____ Citizen: Yes No Va. Resident: Yes No
 Address: _____ Phone: _____

 Employer: _____ Phone: _____
 (If self-employed, identify type of business)
 Employer Address: _____

Spouse/Guarantor Information:

Name: _____ Relationship: Spouse Child Parent other
 Employer: _____ Phone: _____
 Employer Address: _____ DOB: _____
 _____ SS#: _____

Dependent information:

Number of persons, including you, in household that is dependent upon stated income: _____

List of dependents other than patient:

Name:	SS#	DOB	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Financial History-Gross Income:

Salary/Wages	Patient/Guarantor _____	Weekly _____	Bi-Weekly _____	Monthly _____	Yearly _____
	Spouse _____	Weekly _____	Bi-Weekly _____	Monthly _____	Yearly _____
Social Security/SSI	Patient/Guarantor _____	Weekly _____	Bi-Weekly _____	Monthly _____	Yearly _____
	Spouse _____	Weekly _____	Bi-Weekly _____	Monthly _____	Yearly _____
Public Assistance	Patient/Guarantor _____	Weekly _____	Bi-Weekly _____	Monthly _____	Yearly _____
	Spouse _____	Weekly _____	Bi-Weekly _____	Monthly _____	Yearly _____
Self Employment	Patient/Guarantor _____	Weekly _____	Bi-Weekly _____	Monthly _____	Yearly _____
	Spouse _____	Weekly _____	Bi-Weekly _____	Monthly _____	Yearly _____
Child Support	_____	Weekly _____	Bi-Weekly _____	Monthly _____	Yearly _____
TOTAL INCOME	_____	_____	_____	_____	_____

Assets

Bank Accounts:
 Checking _____ (Spouse/Guar.) _____ Name of Bank: _____
 Savings _____ (Spouse/Guar.) _____ Name of Bank: _____
 Other _____ (Spouse/Guar.) _____ Name of Bank: _____
 Vehicles: Year _____ Make _____ Stocks/Bonds _____
 Year _____ Make _____
 Home Value: _____ Mobile Home: _____ Land Value _____ Life Insurance/whole term _____
TOTAL ASSETS TO INCLUDE AS INCOME: _____

Liabilities

Rent Mortgage _____

Utilities:

Gas _____ Monthly Quarterly Bi-Yearly Yearly

Electricity _____ Monthly Quarterly Bi-Yearly Yearly

Water _____ Monthly Quarterly Bi-Yearly Yearly

Telephone _____ Monthly Quarterly Bi-Yearly Yearly

Groceries _____ Monthly Quarterly Bi-Yearly Yearly

Charge Accts/Loans _____ Monthly Quarterly Bi-Yearly Yearly

_____ Monthly Quarterly Bi-Yearly Yearly

_____ Monthly Quarterly Bi-Yearly Yearly

Vehicle Loan _____ Monthly Quarterly Bi-Yearly Yearly

_____ Monthly Quarterly Bi-Yearly Yearly

Medical Bills _____ Monthly Quarterly Bi-Yearly Yearly

_____ Monthly Quarterly Bi-Yearly Yearly

_____ Monthly Quarterly Bi-Yearly Yearly

Total Liabilities

Other Third Party Coverage:

Insurance Company(s): _____ Subscriber # _____
Subscriber# _____

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND I AUTHORIZE THE VCU HEALTH SYSTEM TO VERIFY THIS INFORMATION BY CONTACTING EMPLOYERS OR OTHER AGENCIES AND BY CONDUCTING CREDIT CHECKS. I ALSO AGREE TO PROVIDE VERIFICATION OF MY ABOVE STATED FINANCIAL POSITION WITHIN THE REQUIRED DEADLINE IN ORDER TO BE CONSIDERED FOR ASSISTANCE. IF AT ANY TIME, I OBTAIN INSURANCE OR IF MY FINANCIAL SITUATION CHANGES, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY VCU HEALTH SYSTEM.

I AUTHORIZE VCUHS TO RELEASE MY FINANCIAL RECORDS (INCLUDING SOCIAL SECURITY NUMBER) TO PHARMACEUTICAL COMPANIES AND/OR THEIR AGENTS FOR DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE FOR MEDICATIONS.

Patient/Guarantor: _____ Date: _____
Patient/Guarantor: _____ Date: _____
Interviewer/Witnessed by: _____ Date: _____

OFFICE USE ONLY
Referral for Patient/Family Members made to: Medicaid _____ SLH _____
Comments:

