

Inova Financial Aid application instructions and Required Documents

In order to consider you for financial assistance, the front and reverse sides of the application must be completed and signed by you.

Please provide the following documents that apply to your household. Please submit only copies; no original documents.

- **Copy of 2015 Federal Income Tax Return for Self and Spouse.**
(Please send only the first two pages of your tax return - 1040 forms)
- Two copies of your most recent pay stubs for **Self and Spouse.**

===== **IMPORTANT!** =====

Failure to submit the requested documents will result in the DENIAL of your application leaving you responsible for the entire balance.

If you should have any questions or need additional time to submit your application, please call **571-423-5880**.

If you prefer to send the verifications via fax; our fax number is **571-423-5886**.

Return application and supporting documents to:

**Inova Financial Aid Office
2990 Telestar Ct, 1st floor
Falls Church, VA 22042**

Return completed form to:

Inova
2990 Telestar Ct.
Falls Church, VA 22042

- IMVH IAH
 IFOH IFMC
 IER/FC ILH
 IER/RH

**Patient Accounts
Financial Aid Form**

MEDICAL RECORD / GUARANTOR #			DATE OF SERVICE			ACCOUNT NUMBER			
PATIENT'S NAME - LAST			FIRST		M.I.	SOCIAL SECURITY NO.		HOME PHONE NO.	
ADDRESS			APT. NO.	CITY		STATE	ZIP CODE	PATIENT'S DATE OF BIRTH	
EMPLOYER NAME			EMPLOYER PHONE NO.		NO. OF PERSONS IN FAMILY		PREGNANT?		
FAMILY MEMBER NAME(S)	DATE OF BIRTH	SOC. SEC. NO.	GENDER	RELATION	FAMILY MEMBER NAME(S)	DATE OF BIRTH	SOC. SEC. NO.	GENDER	RELATION
1.	/ /	/	/		4.	/ /	/	/	
2.	/ /	/	/		5.	/ /	/	/	
3.	/ /	/	/		6.	/ /	/	/	

What are the amounts and sources of family income? (Include wages/salary/income from any source for patient and spouse, parents, if patient is minor)

	\$	Please Circle Income Code					\$	Please Circle Income Code			
		W	2W	M	A			W	2W	M	A
1. Wages						8. Other					
2. Other Wages						Exempt Income					
3. General Relief						1. Supplemental Security Income					
4. Social Security / SSI Disability						2. Student Work/Study Loans/Grants					
5. Aid to Dependent Children						3. Federal Entitlements					
6. Alimony/Child Support						4. Other					
7. Unemployment Income											

Income Codes: W = Weekly 2W = Every two weeks M = Monthly A = Annually/Yearly

Is this visit related to: Motor Vehicle Accident? Yes No Injury on your job? Yes No

I certify that the above statements are true and correct to the best of my knowledge and belief. I understand that the hospital will require PROOF OF INCOME (credit report, tax returns, paycheck stubs, disability determination, etc.) and I authorize Equifax Credit Bureau and/or Social Services agencies to release information needed to complete the application process. Further, I will make application for any assistance (Medicaid, Medicare, Insurances, etc.) which may be available for payment of my hospital charge. I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Supporting documentation must be submitted within fifteen (15) days in order for this application to be considered.

APPLICANT'S SIGNATURE: _____ DATE OF REQUEST: _____

TOTAL COUNTABLE INCOME: \$ _____

DO NOT WRITE IN THIS AREA, IT IS FOR OFFICIAL USE ONLY!

TOTAL COUNTABLE INCOME: \$ _____

	100%	400%	500%
1	\$11,880	\$47,520	\$59,400
2	\$16,020	\$64,080	\$80,100
3	\$20,160	\$80,640	\$100,800
4	\$24,300	\$97,200	\$121,500
5	\$28,440	\$113,760	\$142,200
6	\$32,580	\$130,320	\$162,900
7	\$36,730	\$146,920	\$183,650
8	\$40,890	\$163,560	\$204,450

Note: For Households with more than 8 persons, add \$4,160 for each additional person.



If unemployed, please provide previous sources and amounts of gross family income below:

Source: _____

Amount: _____

<p>What is the TOTAL balance in your checking accounts, savings accounts, certificates of deposit, and / or securities accounts?</p>	<p>The <u>total</u> amount is: _____</p>
<p>Do you have any individual retirement accounts? (IRA, 401(k), 401(b), Keogh)</p>	<p><input type="checkbox"/> Yes; the <u>current</u> value is: _____ <input type="checkbox"/> No</p>
<p>Do you own an automobile(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No; if Yes:</p> <p>#1 YEAR _____ #2 YEAR _____ #3 YEAR _____ MAKE _____ MAKE _____ MAKE _____ MODEL _____ MODEL _____ MODEL _____</p>	<p>#1 Value: \$ _____ Payment: \$ _____ Balance Due: \$ _____ #2 Value: \$ _____ Payment: \$ _____ Balance Due: \$ _____ #3 Value: \$ _____ Payment: \$ _____ Balance Due: \$ _____</p>
<p>Do you receive income from interest, dividends, or investments?</p>	<p><input type="checkbox"/> Yes; the <u>total</u> amount is: _____ <input type="checkbox"/> No</p>
<p>Do you: <input type="checkbox"/> Own your home <input type="checkbox"/> Rent your home? If not: where or with whom do you live? _____</p>	<p>If you <u>OWN</u>: Current Value: \$ _____ Monthly Payment / Rent \$ _____</p>
<p>30 Day Residency Verified <input type="checkbox"/> 1 Year Residency Verified <input type="checkbox"/></p>	