



Inova Financial Aid Application Instructions and Required Documents

In order to consider you for financial assistance, both pages of the application must be fully completed and signed by you.

Please also provide the following documents that apply to your household. Please submit only copies, not original documents.

- **Copy** of 2010 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 have questions, please call **571-423-5880**.

Return application and supporting documents to:

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

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



Return completed form to:
INOVA HEALTH SYSTEM
2990 Telestar Ct
Falls Church, VA 22042

IMVH IAH
 IFOH IFH
 IECC/F IFSM
 IECC/R

MEDICAL RECORD #		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 / SS 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.

APPLICANT'S SIGNATURE:

DATE OF REQUEST:

TOTAL COUNTABLE INCOME: \$

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

TOTAL COUNTABLE INCOME: \$

1	0	\$10,890	\$21,780	\$24,503	\$27,225	\$29,948	\$32,670
2	0	\$14,710	\$29,420	\$33,098	\$36,775	\$40,453	\$44,130
3	0	\$18,530	\$37,060	\$41,693	\$46,325	\$50,958	\$55,590
4	0	\$22,350	\$44,700	\$50,288	\$55,875	\$61,463	\$67,050
5	0	\$26,170	\$52,340	\$58,883	\$65,425	\$71,968	\$78,510
6	0	\$29,990	\$59,980	\$67,478	\$74,975	\$82,473	\$89,970
7	0	\$33,810	\$67,620	\$76,073	\$84,525	\$92,978	\$101,430
8	0	\$37,630	\$75,260	\$84,668	\$94,075	\$103,483	\$112,890
	Q100		Q101	Q126	Q151	Q201	Q226

➡ **OVER** ➡

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

Source: _____

Amount: _____

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

PATIENT ACCOUNTS USE ONLY

ELIGIBILITY APPROVED DENIED INOVA FINANCIAL ASSISTANCE

ELIGIBILITY APPROVED DENIED INDIGENT HEALTH CARE TRUST FUND

REASON FOR DENIAL: _____

HOSPITAL REPRESENTATIVE SIGNATURE: _____ DATE: _____

FOR OFFICIAL USE ONLY

Signature _____	Date _____
Signature _____	Date _____
Signature _____	Date _____
Signature _____	Date _____