INOVA

INOVA FINANCIAL AID

Date _____/_____/_____ **IAH IFH IMVH IFOH ILH**

Patient _____

Medical Record Number _____

DEAR PATIENT/GUARANTOR:

I have received your **Inova Financial Aid Form**. In order to process your application, the following information is needed.

Provide indicated documents: (All that apply to you. Only copies please, no originals)

X **Copy** of 2018 Federal Income Tax Return for **Self, Spouse or Domestic Partner**
(Please only send the first 2 pages of your taxes- 1040 forms)

X **Copy** of 2 current Pay Stubs for **Self, Spouse or Domestic Partner.**

- If you get paid in cash, provide a **notarized** letter from your **employer** stating your wages and hours of work, employer's names, address, and phone number.

- Proof of any other type of Income received by ANY member of the **Household/Family**
--- Unemployment, Social Security, Disability, Retirement, Child Support or Alimony.

- Verification of Support (If you and spouse or partner do not work) (Notarized)

- Proof of residency (9 months prior to date of service)

- Self Declaration of Income (Provide year-to-date declaration from your accountant or notarized document from you)

- Other

_____

Failure to submit the requested documents will result in the DENIAL of your application, leaving you responsible for the entire balance.
For any question or if you need more time to gather the documents requested please call at **571-423-5880.**
If you prefer to send the verifications via fax; our fax number is **571-423-5886**.

** **Once verifications of income and family size are received, please allow 30 days for processing the accounts****

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Attach documents to this sheet and mail within fifteen (15) days to:

INOVA Health System
Financial Aid Office
2990 Telestar Court, 1st floor
Falls Church, VA 22042

INOVA®

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Return completed form to:

Inova

2990 Telestar Ct. Falls Church, VA 22042

Patient Accounts
Financial Assistance Form

MEDICAL RECORD / GUARANTOR #	DATE OF SERVICE	ACCOUNT NUMBER

PATIENT'S NAME - LAST	FIRST	M.I.	SOCIAL SECURITY NO.	PATIENT'S DATE OF BIRTH

ADDRESS	APT. NO.	CITY	STATE	ZIP CODE

HOW LONG HAVE YOU LIVED AT THIS ADDRESS?		HOME PHONE NO.

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.	/ /	/ /			3.	/ /	/ /		
2.	/ /	/ /			4.	/ /	/ /		

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

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%	250%	400%	500%
1	$12,490	31,225	49,960	$62,450
2	$16,910	42,275	67,640	$84,550
3	$21,330	53,325	85,320	$106,650
4	$25,750	64,375	103,000	$128,750
5	$30,170	75,425	120,680	$150,850
6	$34,590	86,475	138,360	$172,950
7	$39,010	97,525	156,040	$195,050
8	$43,430	108,575	173,720	$217,150
9	$47,850	119,625	191,400	$239,250
10	$52,270	130,675	209,080	$261,350

Note: For families/households with more than 8 persons, add $4,320 for each additional person.

OVER

CAT #98748 / R013119 • PKGS OF 100

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 total amount is: _____
Do you have any individual retirement accounts? (IRA, 401(k), 401(b), Keogh)	❑ Yes; the current value is: _____ ❑ No
Do you own an automobile(s)? ❑ Yes ❑ 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?	❑ Yes; the total amount is: _____ ❑ No
Do you: ❑ Own your home ❑ Rent your home? If not: where or with whom do you live? _____	If you OWN: Current Value: $ _____ Monthly Payment / Rent $ _____
9 Month Residency Verified ❑	

Notice of Non-Discrimination

As a recipient of federal financial assistance, Inova Health System ("Inova") does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, sex, disability, or age in admission to, participation in, or receipt of the services or benefits under any of its programs or activities, whether carried out by Inova directly or through a contractor or any other entity with which Inova arranges to carry out its programs and activities.

This policy is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act, and regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at 45 C.F.R. Parts 80, 84, 91 and 92, respectively.

Inova:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please let our staff know of your needs for effective communication.

If you believe that Inova has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting our Director of Patient Experience at 703-289-2038. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Director of Patient Experience is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201 1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Interpreter Services are available at no cost to you.

Please let our staff know of your needs for effective communication.

Spanish	Atención: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Por favor infórmele a nuestro personal sobre sus necesidades para lograr una comunicación efectiva.
Korean	알려드립니다: 귀하가 한국어를 구사한다면 무료 언어 도움 서비스가 가능합니다. 효과적인 의사전달을 위해 필요한 것이 있다면 저희 실무자에게 알려주시기 바랍니다.
Vietnamese	Chú ý: Nếu quý vị nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ có sẵn miễn phí cho quý vị sử dụng. Xin vui lòng thông báo cho nhân viên biết nhu cầu của quý vị để giao tiếp hiệu quả hơn.
Chinese	注意：如果你說中文，可以向你提供免費語言協助服務。請讓我們的員工了解你的需求以進行有 效溝通。
Arabic	انتباه: إذا كنت تتحدث العربية، تتوافر الخدمات المجانية للمساعدة في اللغة. يرجى إعلام فريق العمل باحتياجاتك من أجل الحصول على عملية تواصل فعالة.
Tagalog	Atensyon: Kung nagsasalita ka ng Tagalog, mayroong magagamit na mga libreng serbisyong tulong sa wika para sa iyo. Mangyaring ipaalam sa aming mga kawani ang iyong mga pangangailangan para sa epektibong komunikasyon.
Farsi	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی به صورت را یگان برای شما فراهم خواهد بود. به منظور برقراری ارتباط موثر، کارکنان ما را از نیازهای خود مطلع کنید.
Amharic	ትኩረት፡ አማርኛ የሚናገሩ ከሆነ ለእርስዎ የቋንቋ ድጋፍ አግልግሎቶች ከክፍያ በነጻ ይቀርብልዎታል፡፡ ውጤታማ የሆነ ኮሚዩኒኬሽን የሚፈልጉ ከሆነ ሰራተኞችን እንዲያውቅ ያድርጉ፡፡
Urdu	توجہ: اگر آپ اردو بولتے ہیں تو، زبان امداد خدمات، مفت میں، آپ کو دستیاب ہیں۔ موثر مواصلت کے لیے برائے مہربانی ہمارے عملہ کو اپنی ضروریات کے بارے میں بتلا دیں۔
French	Attention: Si vous parlez Francais, des services d'aide linguistique vous sont proposés gratuitement. Veuillez informer notre personnel de vos besoins pour assurer une communication efficace.
Russian	Внимание: Если вы говорите на русском языке, для вас доступны бесплатные услуги помощи с языком. Для эффективной коммуникации, пожалуйста, дайте персоналу знать о ваших потребностях.
Hindi	कृपया ध्यान दें : यदि आप हिन्दी बोलते है, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। कृपया प्रभावी संचार-संपर्क हेतु अपनी आवश्यकताओं के बारे में हमारे कर्मचारियों को बताएं।
German	Achtung: Wenn Sie Deutsch sprechen, stehen kostenlose Service-Sprachdienstleistungen zu Ihrer Verfügung. Teilen Sie unserem Team bitte Ihre Wünsche für eine effektive Kommunikation mit.
Bengali	দৃষ্টি আকর্ষণ করুন : আপনি যদি বাংলা বলতে পারেন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা সেবা পাওয়া যাবে। অনুগ্রহ করে কার্যকরী যোগাযোগের জন্য আপনার প্রয়োজনীয়তার বিষয়ে আমাদের কর্মীদের জানান।
Kru (Bassa)	Tò Ðùǔ Nɔ̀mɔ̀ Dyíin Cáo: Ɔ jǔ ké m̀ dyi Gɔ̀ɖɔ̀ɔ̀-wùɖù (Ɓǎsɔ́ɔ̀-wùɖù) po ní, nìí, à ɓéɖé gbo-kpá-kpá ɓó wuɖu-dù kò-kò po-nyɔ̀ ɓě bìì nɔ̄ à gbo ɓó pídyi. M̀ dyi ɖɛ ɖò mɔ́ nɔ̄ à gbo ní, m̀ mɛ nyuɛ ɓé à kǔà-nyɔ̀ ɓěɔ̀ kéɛ dyí dyuò, ké à kè mɔ̀ kè muɛ jè cɛ̃ìn nɔ̀mɔ̀ dyíin.
Ibo	Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịrị gị. Biko mee ka ndị ọrụ anyị mara mkpa gị maka nkwukọrịta ga-aga nke ọma.
Yoruba	Akiyesi: Bi o ba nsọ Yoruba, awọn iṣẹ iranilọwọ ede wa l'ọfẹ fun ọ. Jọwọ jẹ ki ara ibiṣẹ wa mọ nipa awọn aini rẹ fun ibaraẹnisọrọ ti o munadoko.

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