Financial Statement Form

Patient Information

Full Name_____ Date of Birth_____

Medical Record Number_____ SSN_____

Martial Status _____ Citizen ❑ Yes ❑ No Virginia Resident ❑ Yes ❑ No

Street Address _____

Phone_____ Email _____

Employer* _____ Phone _____

Employer Address _____

Spouse and/or Guarantor Information

Full Name_____

Relationship ❑ Spouse ❑ Child ❑ Parent ❑ Other _____

Date of Birth _____ SSN _____

Phone_____ Email _____

Employer* _____ Phone _____

Employer Address _____

Dependent Information

Number of persons, including you, in household that is dependent upon stated income _____ . Please list dependents other than patient below:

Name	**SSN**	**DOB**	**Relationship**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Gross Income

Salary/Wages	Patient_____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
	Spouse _____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
Social Security/SSI	Patient_____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
	Spouse _____	❑ Weekly	❑ BiWeekly	❑ Monthly	❑ Yearly
Public Assistance	Patient_____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
	Spouse _____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
Self-Employment	Patient_____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
	Spouse _____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
Child Support	Patient_____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly
	Spouse _____	❑ Weekly	❑ Biweekly	❑ Monthly	❑ Yearly

Total Income _____

*If self-employed, identify type of business

VCU Health™

Financial Counseling Call Center
(804) 828-0966
1-800-762-6161 Toll Free
Monday-Friday, 9 a.m. to 4 p.m.

rev. 05/16

Assets

Bank Accounts:

Checking _____ Spouse _____ Name of Bank _____

Saving_____ Spouse _____ Name of Bank _____

Other _____ Spouse _____ Name of Bank _____

Vehicles:

Year_____ Make_____ Model _____

Year_____ Make_____ Model _____

Home Value_____ Mobile Home_____ Land Value _____

Life and/or Whole-term Insurance _____ Stocks and/or Bonds _____

Total Assets _____

Liabilities

Rent _____ Mortgage _____

Utilities:

Gas _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Electricity _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Water _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Telephone _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Groceries _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Charge Accounts and Loans:

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Vehicle Loans:

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Medical Bills

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

_____ _____ ❑ Monthly ❑ Quarterly ❑ Biannual ❑ Yearly

Total Liabilities _____

Other Third Party Coverage:

Insurance Companies _____ Subscriber No. _____

_____ Subscriber No. _____

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 VCU Health System to release my financial records (including Social Security Number) to pharmaceutical companies and/or their agents for determining eligibility for financial assistance for medications and other assistance programs.

Patient Signature _____ Date _____

Spouse/Guarantor Signature _____ Date _____

Interviewed/Witnessed By_____ Date _____