FAUQUIER HOSPITAL

Revised 05/2021

Financial Assistance Application

1. Patient Information

Patient's Name: _____
First M.I. Last

Patient's Address: _____
Street City State / Zip Code

Patient's Phone Number: _____

Patient's Date of Birth: _____ Patient's Marital Status: _____
Single or Married

Patient's Social Security Number: _____

Patient's Account Number: _____

2. Guarantor Information

Guarantor's Name: _____
First M.I. Last

Guarantor's Address: _____
Street City State / Zip Code

Guarantor's Phone Number: _____

Guarantor's Date of Birth: _____ Guarantor's Marital Status: _____
Single or Married

Guarantor's Social Security Number: _____

Guarantor's Relationship to Patient: _____

3. Spouse Information

Note: If the patient/guarantor is married, then spouse's financial information and signature are required in order to process this application.

Spouse's Name: _____
First M.I. Last

Spouse's Address: _____
Street City State / Zip Code

Spouse's Phone Number: _____

Spouse's Date of Birth: _____

Spouse's Social Security Number: _____

4. Household Information

Dependents

Name	Relationship	Date of Birth

Employment and Insurance Information

	Patient/Guarantor	Spouse
Name of employer (If unemployed, write "none")		
Are you in school? (If yes, write name of school)		
Do you have health insurance? (Y/N)		

	Patient/Guarantor	Spouse
If no, is health insurance available through your employer or school? (Y/N)		
Do you have Medicare? (Y/N)		
Do you have Medicaid? (Y/N)		
Do you receive Veteran's Benefits? (Y/N)		

Total Household Income

Please note your household's total monthly income from all sources:

□ Wages	$_____	□ Tips	$_____
□ Self-Employment	$_____	□ Business Profits	$_____
□ Interest Income	$_____	□ Dividends	$_____
□ SSI/Social Security	$_____	□ Rental Income	$_____
□ Child Support	$_____	□ Alimony	$_____
□ Veteran's Benefits	$_____	□ Worker's Comp.	$_____
□ Unemployment	$_____	□ Food Stamps	$_____
□ Pension/Retirement	$_____	□ Farm Income	$_____
□ Insurance/Annuities	$_____	□ Public Assistance	$_____
□ Trust Income	$_____	□ Other	$_____

5. Required Documentation

Attach copies of the documents listed below for both the patient/guarantor and spouse (please submit only copies; no original documents):

- Most recent tax return, including W-2 forms and supporting schedules
- Last 2 pay stubs or a letter from an employer verifying income (include employer's phone number and address)
- Bank statements for the past 2 months
- Written verification of any other income received (e.g. child support, social security, alimony)

OR

- **If you have no income, a notarized letter of support is required.**

6. Other Comments

7. Acknowledgement

I hereby acknowledge that the information in this application (including any attachments) is true, complete and accurate to the best of my knowledge. Furthermore, I understand that to qualify for Financial Assistance, I must take all steps necessary to apply for and obtain any other available payment sources (such as Medicaid, Medicare, insurance, etc.).

I hereby authorize **Fauquier Hospital** to contact any person, firm or organization to verify any of the information given, and I hereby authorize any such person, firm or organization to release such information to **Fauquier Hospital**. I also authorize **Fauquier Hospital** to request a consumer credit report.

Patient/Guarantor's Signature: _____

Date

Spouse's Signature: _____

Date

8. Mailing Instructions / Contact Information

Mail (or hand deliver) your complete Financial Assistance Application with documentation to:

Fauquier Hospital
Attn: Financial Counselors
500 Hospital Drive
Warrenton, Va 20186

For additional information about **Fauquier Hospital**'s Financial Assistance Policy, or for assistance with this application, please call Patient Financial Services at **540-316-2970** or visit a Financial Counselor at the above address.

Please allow 30 days for processing.

For Internal Use Only

Processed By: _____ Date: _____
Financial Counselor

Eligibility Determination: ( ) Yes ( ) No Discount: _____%

If denied, state reason: _____

Reviewed/Approved By: _____ Date: _____
Patient Access Manager/Director (or designee)

_____ Date: _____
Patient Financial Services Director (or designee)

_____ Date: _____
Hospital Controller/CFO (or designee)

Instructions for Completing Fauquier Hospital Financial Assistance Application

1. Patient Information

Patient's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient.

Patient's Address: Clearly print on the blank line the address where the patient lives including the city, state and zip.

Patient's Phone Number: Clearly print on the blank line the patient's phone number.

Patient's Date of Birth: Clearly print on the blank line the patient's date of birth.

Patient's Marital Status: Clearly print "single" or "married".

Patient's Social Security Number: Clearly print on the blank line the patient's social security number.

Patient's Account Number: Clearly print the medical record number **Fauquier Hospital** has issued the patient (or the Guarantor's ID # if the application is for a dependent's balances).

2. Guarantor Information (Complete if applicable)

Guarantor's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient's parent, legal guardian or other responsible person ("guarantor").

Guarantor's Address: Clearly print on the blank line the address where the guarantor lives including the city, state and zip.

Guarantor's Phone Number: Clearly print on the blank line the guarantor's phone number.

Guarantor's Date of Birth: Clearly print on the blank line the guarantor's date of birth.

Guarantor's Marital Status: Clearly print "single" or "married".

Guarantor's Social Security Number: Clearly print on the blank line the guarantor's social security number.

Guarantor's Relationship to Patient: Describe what the guarantor's relationship is to the patient (for example, parent or legal guardian).

3. Spouse Information (Complete if applicable; may be skipped if patient/guarantor is single)

Spouse's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient/guarantor's spouse.

Spouse's Address: Either clearly print on the blank line the address where your spouse resides (or indicate "Same" if you and your spouse reside at the same address).

Spouse's Phone Number: Clearly print on the blank line your spouse's phone number.

Spouse's Date of Birth: Clearly print on the blank line your spouse's date of birth.

Spouse's Social Security Number: Clearly print on the blank line your spouse's social security number.

4. Household Information

Dependents: Clearly print the name, relationship and date of birth for each person in your household whom you can claim as a dependent on your taxes (children or adults for whom you financially provide more than 50% of their living expenses). You may attach additional sheets of paper if more space is needed.

Employment and Insurance Information: For both patient/guarantor and your spouse, answer each of the questions indicated. Write "Yes" or "No" or provide the requested information in each applicable box.

Total Household Income: Clearly print the total income your household (yourself, your spouse, and dependents) receives each month from all sources. You may attach additional sheets of paper if more space is needed.

- If your household receives income from a source that you do not see listed, please indicate that amount on the line for "Other."
- If your household receives income from a source that is not paid to you every month, take the total amount you have received from that source during the past 12 months, divide it by 12, and then indicate that amount on the application.

5. Required Documentation

The documents listed in this section are needed to help us determine if you qualify for financial assistance under **Fauquier Hospital**'s Financial Assistance Policy. If you do not have, or cannot produce the items listed, please include an explanation as to why. Please note that additional information or documentation may be requested by the Patient Financial Services staff when processing your application.

6. Comments

Use this section to share any additional information you would like us to consider in the evaluation of your Financial Assistance Application.

7. Acknowledgement

Patient/Guarantor's Signature: Carefully read the acknowledgement statement in this section and then sign and date the application.

Spouse's Signature: Have your spouse (if married) carefully read the acknowledgement statement in this section and then sign and date the application.

8. If unemployed, Notarized Letter of Support

If applicant is unemployed, a notarized letter of support is required. Please do not fill out until in front of a certified Notary of the Public.