



**BON SECOURS HEALTH SYSTEM
FINANCIAL ASSISTANCE APPLICATION**

Date Sent _____

Facility _____ Account # _____
 Patient Last Name _____ First _____ MI _____
 SS# _____ Date of Birth _____ Marital Status _____ Phone# _____
 Patient Address _____
 Employer _____ Spouse's Employer _____

Family Members (List spouse and dependent children under 18 years, or as listed on your taxes and their date(s) of birth):

Name	Date of Birth	Name	Date of Birth
1. _____ / _____	4. _____ / _____		
2. _____ / _____	5. _____ / _____		
3. _____ / _____	6. _____ / _____		

APPLICANTS MUST SUBMIT ALL REQUIRED DOCUMENTS IN THE SAME MAILING TO:

*Bon Secours Financial Assistance Program
 P.O. Box 1449
 Kilmarnock, VA 22482*

Please answer each question and provide the information requested

UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE

DECISIONS WILL BE RENDERED WITHIN 60 DAYS OF RECEIPT OF COMPLETED APPLICATION AND PARTICIPATION WITH OUR VENDOR

Please answer all questions listed below	If YES, please provide the following for <u>EACH</u> member of the household receiving the benefit.
Is any member of your household self-employed ? <input type="checkbox"/> YES <input type="checkbox"/> NO	COMPLETE TAX form(s) including business taxes from the most recent tax year and latest quarterly filing listing income for quarter
Is any member of your household employed ? <input type="checkbox"/> YES <input type="checkbox"/> NO	3 most recent pay stubs or signed letter from employer
Is any member of your household receiving unemployment benefits ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Benefit letter or Unemployment printout from State website
Is any member of your household receiving Social Security ? <input type="checkbox"/> YES <input type="checkbox"/> NO	SS benefit letter or complete bank statement if direct deposited
Does any member of your household receive a Pension or Retirement ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Pension/Retirement letter or complete bank statement if direct deposited
Does any member of your household receive SNAP benefits ? <input type="checkbox"/> YES <input type="checkbox"/> NO	SNAP Letter
Does any member of your household receive a Child Support ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Court ordered document or letter from non-custodial parent
Does any member of your household own rental or investment property ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Rental agreement/documentation listing income amount
Does any member of your household have other sources of Income ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Stocks, Bonds, CD's additional property, etc... Attach current statement(s)
Does any member of your household have a checking, savings or money market account ? <input type="checkbox"/> YES <input type="checkbox"/> NO	Attach complete copy of current 30 day statement for <u>each</u> account
NO INCOME: <input type="checkbox"/> YES <input type="checkbox"/> NO If your household is claiming no income you must have the person providing your food, shelter, and daily living expenses sign below and indicate which type of assistance they are providing I certify that I (name) _____ (phone number) _____ provide food, shelter, and daily living expenses for the patient listed above and/or income of \$ _____ Monthly Assistance provided: _____ Signature _____ Relationship _____ Date _____	

Applicants on a student or tourist VISA must provide a copy of all insurance, financial, and/or sponsorship information provided to obtain the visa.

>>>Continued<<<



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Personal Asset Value List

Annual Household Income	_____	CD's (Cash Value)	_____
Cash on Hand/Money in Bank/Savings Acct(s)	_____	Primary residence (Cash Value)	_____
Monthly Rent	_____	Other Real Estate (Cash Value)	_____
Monthly Mortgage payment	_____	401k (Cash Value)	_____

Was treatment for this service due to an accident? Yes _____ No _____ **(Financial Assistance program does not apply to treatment related to work injuries, cosmetic procedures or flat rate procedures, accidents or other treatment for which you receive compensation for your medical bills, pain and suffering and other damages).**

Do you have health insurance YES NO (If YES, please provide further information below)

- Insurance Name _____ Policy Holder Name _____ Policy# _____
- Insurance Name _____ Policy Holder Name _____ Policy# _____

I hereby request that Bon Secours Health System Inc., make a written determination of my eligibility for financial assistance. I understand that, if the information which I submit is determined to be false, such determination may result in a denial of my application and that I may be liable for charges for services provided. I certify that the above information is true, complete, and correct to the best of my knowledge. I acknowledge that cooperating with the eligibility screening vendor is required to be considered for financial assistance.

Additional Comments

Signature of Responsible Party: _____ **Date:** _____

Bon Secours Health System Inc., reserves the right to validate information reported in the Financial Assistance application, such efforts to validate personal income or lack thereof, will be conducted in such a manner as to maintain the utmost confidentiality and in no way generate any report by any credit bureau agency that could adversely affect the privacy of the applicant.

If you need additional assistance, please visit a financial counselor at your local Bon Secours hospital or call our Customer Service Department.

Rappahannock General Hospital 804-435-8529