Sheltering Arms Financial Assistance Application

Applicant's Name: Last:	First:	Age:	Date of Birth:	Services: ☐Inpatient ☐ Psychology ☐Outpatient ☐ Physicians ☐Other:_______________
		Sex M - F	Are you a US Citizen or legal resident alien ☐Yes ☐No	

Street Address	City	State	Zip code

Marital Status S M D W	Employment Status Work☐ Unemployed☐ Retired☐	Home Phone or Cell	Work Phone

Applicant's employer name	Employer's Street Address	City	State	Zip code
Spouse's employer name	Employer's Street Address	City	State	Zip code

Is there government or private insurance coverage available? ☐Yes ☐No	**Is there a 3rd party liability claim involved in this case? ☐Yes ☐No**

Number of dependents claimed in last year tax return #:

Dependent's Name	Relationship	Age
Dependent's Name	Relationship	Age
Dependent's Name	Relationship	Age

INCOME AND RESOURCES SECTION

Gross Monthly Income (before taxes) Applicant $___________________ Spouse $___________________	Verification method (required) ☐ Paystub ☐ W2 or 1099 ☐ Retirement award letter ☐ Court order

Monthly Retirement: $ ______________ Interest/Dividend: $ ______________	Rental income: $ ________________ SSI: $ ________________	Annuity: $________________ Alimony $________________	Other: $ ______________ W, B, M

If zero income is reported a letter of support or room and board is required

RESOURCE INFORMATION

Checking balance: $_______________Acct#__________________ Saving balance: $_______________Acct#__________________ CDs balance: $_______________Acct#__________________	Home equity: $ ______________	

Sheltering Arms Medical Expenses

Provider:____________________________________ Balance $ _____________ Monthly Payment $ _________________

Provider:____________________________________ Balance $ _____________ Monthly Payment $ _________________

Provider:____________________________________ Balance $ _____________ Monthly Payment $ _________________

Provider:____________________________________ Balance $ _____________ Monthly Payment $ ________________

Per visit Co-pay	$	**DME -** If you expect durable medical equipment will be necessary, please fill in these fields: Weight: _______, Weight: _______.
Deductible	$	

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Monthly medication cost	$	The device requested will help with: Home ☐ School ☐ Work ☐ Community Activities ☐

OTHER RESOURCES

Is your treatment the result of an accident or injury involving litigation? ☐YES ☐NO. If "YES", answer questions 1-3 below

1. Name of Attorney : ____
2. Firm attorney works for: ____
3. Firm's Address and phone number: ____

Have you applied for:			
1. Social Security Disability	☐ Yes Date: ____________	State Applied:_________	☐ No
2. Supplemental Security Income	☐ Yes Date: ____________	State Applied:_________	☐ No
3. Medicaid	☐ Yes Date: ____________	State Applied:_________	☐ No

HEALTH INSURANCE

List all available health insurance coverage:

Health plan name:	Policy ID:	Group#:	Subscriber:
Health plan name:	Policy ID:	Group#:	Subscriber:
Health plan name:	Policy ID:	Group#:	Subscriber:

I certify that all information on this application is true and correct to the best of my knowledge and that all income and resources are reported. I understand that any approval of financial assistance will be voided by failure to provide accurate information, including, but not limited to legal representation, financial information, and insurance information. I understand that I am required to first utilize any other third party payment source, including fully collaborating with Sheltering Arms selected insurance advocacy firm, to determine my eligibility for other payment sources. If I am eligible for any type of medical or financial assistance through the state or other resources, I agree to do whatever is necessary to apply for that program as requested by Sheltering Arms. In order to verify the accuracy of the information presented in the application, Sheltering Arms will require documents which may include, but not be limited to, some combination of the following:

-Last 3 paystubs and/2 years tax returns
-Social Security/Disability Certification letter
-Welfare Benefit Letter
-Notarized letter of support
- Bank Account statement for 2 previous months
- Documentation of Virginia Residency
- CDs, Home equity value

Failure to provide the necessary supporting documentation will result in delays and or the potential denial of request for financial assistance. Financial Assistance is only available to patients after they have pursued all other insurance coverage options (including Medicaid). For more information you can visit our website at: https://www.shelteringarms.com/patients-visitors/financial-assistance-policy/. You may also contact us at and submit your completed application to the address and phone number listed below.

Patient Accounting
8254 Atlee Rd, Mechanicsville, VA 23116
Telephone: (804) 342-4113
Fax: (804) 342-4317
e-mail: FinancialAssistance@Shelteringarms.com

________________________________ ________________________________ ________________

Patient/Responsible Party Signature Relationship Date