Mary Washington Healthcare

Dear Valued Patient,

Thank you for entrusting Mary Washington Healthcare with your care. Our mission is to improve the health of people in the communities we serve. For over 120 years, we have cared for patients regardless of their ability to pay and we believe concerns about cost should never be a barrier to receiving the care you need. If you need help paying your medical bills, we're here for you. Mary Washington Healthcare offers financial assistance for patients who qualify. To see if you qualify, please follow these steps:

1. If you do not have medical insurance, please call 1.855.242.8282 or visit https://coverva.org/apply to apply for Medicaid or FAMIS benefits.
2. Complete and sign the attached Patient Financial Assistance application for all household members.
3. Provide **copies** of these supporting documents:
   - ☐ Two current pay stubs for Self, Spouse, or Domestic Partner
   - ☐ Most recent Federal Income Tax Return for Self, Spouse, or Domestic Partner
   - ☐ Proof of income* from all sources, for all household members. *(All that apply to you.)*
     - Two most recent bank statements
     - Unemployment income
     - Retirement
     - Disability determination
     - Child support or alimony
     - Social Security

     **If you do not have proof of income, please provide a notarized letter of support demonstrating how you are paying for your living expenses. This letter should be from a family member, friend, or organization that supports your living needs.*
   - ☐ State or federal assistance program verification (SNAP/food stamps, WIC, TANF, housing assistance, homeless clinic, free/reduced school lunch)
   - ☐ Medical insurance cards (front and back) if you have coverage
   - ☐ Auto insurance company denial letter, if visit was due to a motor vehicle accident
   - ☐ Worker's compensation denial letter, if visit was due to a work-related injury/illness

Financial assistance application and all requested documents may be mailed to:

Mary Washington Healthcare
Attn: Financial Counseling
2300 Fall Hill Avenue, Suite 101
Fredericksburg, VA 22401

Upon receiving your application, we'll find programs you are eligible for and send you a letter detailing the options available to you. If you need help completing the application or if you have questions, please don't hesitate to call 540.741.1041 or 800.395.2455 to connect with our Financial Counselors. Counselors are available Monday through Friday, 8:00 a.m.–4:30 p.m.

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APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name: Last	First	M.I.
Street Address:	Patient's Date of Birth:	Patient's Social Security Number:
City, State, and Zip:	Patient's Phone Number:	

Marital Status: (Check one): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Visit related to (Check one): Motor Vehicle Accident: ☐ Yes ☐ No Work Injury: ☐ Yes ☐ No

Are you a U.S. citizen? ☐ Yes ☐ No | Are you a Virginia resident? ☐ Yes. If Yes, # of years: _____ ☐ No

Employment Information

Employer Name:	Employer Phone Number:

* If unemployed, provide the date employment ended: _____ Have you applied for unemployment? ☐ Yes ☐ No

Household Information Number of Persons in Family:_____

Family Member Name(s)	Relationship	Date of Birth	Last 4 SSN	Employer/School	Employment Dates

Does anyone listed above receive any of the following assistance? If so, you may qualify under our presumptive eligibility clause. Please check all that apply and attach a copy of your award letter.

☐ Free/Reduced School Lunch ☐ Food Stamps/SNAP
☐ General Relief ☐ WIC
☐ Homeless Shelter/Clinic ☐ TANF
☐ Housing Assistance (Section 8/HUD)

Patient of:
☐ Lloyd F. Moss Free Clinic ☐ Guadalupe Free Clinic
☐ Living Water Community Clinic ☐ Community Health Ctr
☐ Fredericksburg Christian Health Ctr

What are the amounts and sources of family income? *(Include income for patient/spouse and parents if patient is a minor.)*

Type of Income	Amount	Frequency	Type of Income	Amount	Frequency
Wages	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly	Supplemental Security Income	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly
Other Wages	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly	Student Work/ Study Loans/Grants	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly
General Relief	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly	Federal Entitlements	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly
Alimony/Child Support	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly	Other	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly
Social Security/ SSI Disability	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly	If no income listed, how are you paying your expenses?		
Aid to Dependent Children	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly			
Unemployment Income	$	☐ Weekly ☐ Bi-Weekly ☐ Monthly	*Please provide notarized letter of support of no income.*		

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What is the TOTAL balance in your checking accounts, saving accounts, and/or certificates of deposits? _____	Total monthly living expenses: _____
Do you have any individual retirement accounts? (IRA, 401(k), 401(b))	☐ Yes: The current value is: _____ ☐ No

Do you own or rent any real estate? ☐ Yes. If yes, please complete the below. ☐ No

Address:	Residency Status	Fair Market Value:	Monthly Payment:
	☐ Rent ☐ Own	$	$
	☐ Rent ☐ Own	$	$
	☐ Rent ☐ Own	$	$

Do you own an automobile(s)? ☐ Yes. If yes, please complete the below. ☐ No

Year	Make	Model	Value:	Payment:	Balance Due:
			$	$	$
			$	$	$
			$	$	$

Insurance Eligibility: Please check your answer for each question below.		
Does your employer offer health insurance?	☐ Yes	☐ No
Are you eligible for health insurance through your or your spouse's employer?	☐ Yes	☐ No
Have you been screened ineligible or denied Medicaid? If yes, provide proof of denial.	☐ 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 (*bank statements, tax returns, paycheck stubs, disability determination, credit report, etc.)* and I authorize a Credit Bureau and/or Social Services agencies to release information needed to complete the application process. Further, I will apply for any assistance (*Medicaid, Medicare, Insurances, etc.)* which may be available for payment of my hospital charges. 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.

Please provide supporting documentation within thirty (30) days of applying to keep your application active.

Applicant's Signature:	Date:
Spouse's Signature:	Date:

PLEASE RETURN THIS COMPLETED FORM TO:
Mary Washington Healthcare
Attn: Financial Counseling
2300 Fall Hill Avenue, Suite 101
Fredericksburg, VA 22401

If you have questions, please call **800.395.2455 or 540.741.1041.**