ValleyOpenMRI

FINANCIAL ASSISTANCE APPLICATION

ALL QUESTIONS MUST BE ANSWERED

PART 1: IDENTIFICATION INFORMATION.

Patient Name:	Social Security Number:
Street Address:	Birth Date:
City, State, Zip:	
Marital Status: (**Circle One**) Single Married	Pt Telephone Number:

PART 2: HOUSEHOLD MEMBERS' INFORMATION. Provide income information for the past 12 months for all members of the household. Use a separate line to indicate multiple employers. Please attach a separate piece of paper if more room is needed. **See instructions for information on whom to include as a member of the household**

Household Members, Including Patient	Social Security Number	Date of Birth	Relation to Patient	Employer	Dates of Employment	Monthly Income

Are you (patient) unemployed? Yes / No

If unemployed:
Date Employment Ended ___________. Have you applied for Unemployment? Yes / No

Does someone provide support for you? Yes / No If yes, provide a letter of support written by the person(s) providing that support.

Does anyone in your household receive any of the following types of assistance? **(Circle answers, provide MONTHLY amounts if Yes)**

Medicaid:: Yes / No Housing (Section 8/HUD): Yes/No

Child Support: Yes / No Amount: _______ Alimony: Yes / No Amount: _______ Food Stamps: Yes / No Amount: _______

General Relief: Yes / No Amount: _______ Workers' Compensation Benefits/Unemployment: Yes / No Amount: _______

Disability/Social Security Benefits/Pension/Retirement: Yes / No Amount: _______

PART 3: ASSET INFORMATION. Do not include your primary residence (home). Please attach a separate piece of paper if more room is needed.

Checking Acct Yes / No (Circle One) Acct Num:	Bank Name:	Balance: $
	Location:	
Savings Acct Yes / No (Circle One) Acct Num:	Bank Name:	Balance: $
Stocks, Bonds, CDs, Investments Yes / No (Circle One)	Bank/Broker Name:	Balance: $
	Location	
Retirement Accounts Yes / No (Circle One) Balance:	Type: IRA / 401(k) / 403 (b) / Other	Balance:
Other Property (land or buildings) Yes / No (Circle One)		
Address: Rental Income	Amount Received per year	Approx Value: $

PERSONAL PROPERTY List all vehicles including cars, trucks, motorcycles, motor homes, boats, airplanes or other

Item: Make/model Year Owner: Amt Owed: $ Value: $
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PART 4: EXPENSE INFORMATION. Fill out below, adding expenses not listed. Please attach a separate piece of paper if more room is needed

EXPENSE	MONTHLY AMOUNT	EXPENSE	MONTHLY AMOUNT
Mortgage/Rent		Credit Card Pmts $	
Utilities, Including Cable		Medical Bills $	
Auto Payments		Other: Description & Amount	
Auto / Life Insurance			
Groceries			
Student Loans			
Other Loans			

PART 5: MISCELLANEOUS INFORMATION

Does the patient have health insurance coverage, veteran's administration, or other government benefits? Yes / No
Was patient offered health insurance through employer? Yes / No
If so, why does patient not have coverage?

____
____
____

Was patient screened for Medicaid? Yes / no
If so, why does patient not have Medicaid or FAMIS ?

____
____
____

If not, why was patient not screened for Medicaid?

____
____
____

Other Notes

____
____
____

PART 6: DECLARATION AND SIGNATURE

DECLARATION OF UNDERSTANDING: The information provided on this financial statement is complete and accurate to the best of my knowledge and belief. I must provide verification for the income and assets listed above in order to be considered for financial assistance. My application will be reviewed and additional documentation or explanation may be necessary. Any documents I submit with this application will not be returned. VOM may obtain a credit report during the review process. It is my responsibility to inform VOM if my financial situation changes. Not all VOM services are eligible for financial assistance. VOM may change its financial assistance program at any time and without notice. It is my responsibility to ensure that services I expect to receive qualify for financial assistance before I receive them. It is against the law to provide false information in order to receive financial assistance.

My signature below indicates my understanding of the above information

Applicant's Signature:	Date:

Application must be completed and returned to Quantum Medical, 119 Creekside Lane, Winchester, VA. 22602 (1 week prior to service)

This application must be signed in order to be considered complete. Incomplete applications will not be approved for financial assistance.

THIS SECTION FOR VOM USE ONLY

______ Approved
______ Denied Why? ______________________________
VOM Representative's Signature: ______________________ Date: ____________

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AUTHORIZATION FOR RELEASE OF INFORMATION

To Whom It May Concern:
I hereby authorize you to release to VOM all of the information that is requested below.

Name: ______________________ DOB: ________________ SS#: ______________

☐ Employment and Wage Verification
Please provide the dates of employment and salary information for the above named employee.

☐ Bank Statement Verification
Please provide a copy of the above named person's three most recent bank statements.

☐ Other
Please provide the following information for the above named person.

____

____

____

Thank you for providing this information.

Patient Signature: ____________________________ Date: ______________________

Application must be completed and returned to Quantum Medical, 119 Creekside Lane, Winchester, VA. 22602 (1 week prior to service)

Valley Open MRI
1830 Amherst St.
Winchester, V.A. 22601