Sheltering Arms Institute

A collaboration with VCUHealth

Financial Assistance Program Application

Please return the Financial Assistance Application with your financial documents and completion of the following questions. **ALL** questions must be completed **BEFORE** the application will be reviewed.

Checklist:

- Picture ID
- Proof of income (Only **one** of the following is needed: last 3 pay stubs, last year's tax return, disability letter, or last month's bank statement)
- Completed four-page financial aid application

1. _____

   Patient's Name Patient's Date of Birth

2. Discharge Disposition: If 24-hour supervision/assistance is needed at the time of discharge from Sheltering Arms Institute, who will be providing this care? **Please list all names and phone numbers below.**

   _____

   _____

   _____

3. Address of where the patient will live at time of discharge, if different than current address.

   _____

   _____

4. If income is zero "0" on your financial application, please explain how you are living/ paying expenses.

   _____

   _____

   _____

   _____

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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☐	Occupation	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	$	

Updated March 2023

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 2. Supplemental Security Income 3. Medicaid	☐ Yes Date: _____ ☐ Yes Date: _____ ☐ Yes Date: _____	State Applied:_____ State Applied:_____ State Applied:_____	☐ No ☐ No ☐ 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 pay stubs 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://shelteringarmsinstitute.com/patients-and-visitors/financial-assistance-fees/. You may also contact us at and submit your completed application to the address and phone number listed below.

Patient Accounting
140 Eastshore Drive, Suite 200, Glen Allen, VA 23059
Telephone: (804) 342-4113
Fax: (804) 342-4317
E-mail: FinancialAssistance@shelteringarms.com

_____ _____ _____

Patient/Responsible Party Signature | Relationship | Date

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SUBJECT: Sheltering Arms Institute Letter of Support

I, _____, will provide shelter, financial and physical assistance

(Name and Relationship to Patient)

to _____ following release from Sheltering Arms Institute.

(Patient's Name)

I understand that the average stay at Sheltering Arms Institute is 7-21 days depending on medical doctor and therapist recommendations based on assessment.

I, _____, will be taking _____ to the address of

_____ at the time the medical doctors

deem appropriate for discharge despite progress made. I understand 24/7 care may be required and

I, _____, will provide that.

_____ _____

(Signature) (Date)