Mother of Mercy Free Medical Clinic
703-335-2779
703-420-8993 -Fax

Pt. ID #_____

Pregnant? ❑YES ❑NO

Financial Review

Patient Name: _____
Last Name First Name Middle Name

_____
SSN DOB Gender

Address: _____
Number and Street City/State Zip Code

Telephone: _____ **Race/Ethnicity**: _____ **Primary Language** _____

Email: _____ **Emergency Contact Relationship:** _____

Emergency Contact Name: _____ **Emergency Contact Telephone:** _____

Marital Status: ❑ Married ❑ Partner ❑ Single ❑ Separated

Family Size (Spouse and children under 18) Adults _____ Kids _____ **Total** _____

Dependent Name	DOB	Dependent Name	DOB

PATIENT Employment/Income Summary:
Are you employed? ❑ Yes ❑ No, why_____
If not employed, how do you support yourself? _____
If employed, name of employer? _____
How are you paid? ❑ Paycheck ❑ Cash
How frequently do you get paid? ❑ Weekly ❑ Every two (2) weeks ❑ Monthly ❑ Sometimes
How much is each paycheck? _____
Did you file your taxes last year? ❑ Yes ❑ No

Employment of SPOUSE/PARTNER:
Is he/she employed? ❑ Yes ❑ No, why _____
If not employed, why? _____
If employed, name of employer? _____
How is he/she paid? ❑ Paycheck ❑ Cash
How frequently is he/she paid? ❑ Weekly ❑ Every two (2) weeks ❑ Monthly ❑ Contract/Gig
How much is each paycheck? _____
Did he/she file taxes last year? ❑ Yes ❑ No

PLEASE GO TO NEXT PAGE TO COMPLETE AND SIGN THE APPLICATION!

CONDIFENTIAL

CATHOLIC CHARITIES DIOCESE OF ARLINGTON

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Insurance Verification
Do you have health insurance? Yes ☐ No ☐
If you have insurance, what's the name of your insurance company? _____
If you **DO NOT** have insurance, why? _____
Are you covered or eligible for Medicaid/Medicare? Yes ☐ No ☐ If yes, have you applied Yes ☐ No ☐
If **NOT**, why? _____

I, _____, due hereby swear that I have no medical health insurance for payment of medical bills. I hereby state that I am not qualified to collect medical benefits under the policy of any relative.

Charity Care Program
Have you applied for financial assistance with Novant Health or Sentara Healthcare? Yes ☐ No ☐
If Yes, when? _____

_____ (initials) I certify that the information provided is true to the best of my knowledge. I understand that fraudulent or misleading information may be cause for denial of services. I understand my information is confidential and will not be used for any purpose other than to verify eligibility for clinical services. I understand that proof of income is required, which can include: copy of paycheck stubs, copy of last year's tax returns, W-2, 1099, income verification form, or affidavit of no income. I will also be required to present a photo ID (Driver's License or other government issued ID form my country), proof of residence (rental agreement, bills in my name, or house deed), and proof of no or limited insurance (employer letter of no insurance, self-employment documentation, limited insurance plan, affidavit of no insurance, ineligible for Medicaid/Medicare). I understand I will need to recertify my eligibility for services every six months if I am approved or I may reapply for services if my circumstances change.

I confirm that the following information is included in my application:

- ❑ Proof of Identity (*driver's license, or passport*)
- ❑ Proof of Income or support (*paystubs, Social Security income, SNAP, TANF, affidavit of support, and/or verification of income*)
- ❑ Proof of Residence (*rental lease agreement, utility bill, bank statement, or medical bill*)

APPLICATION WILL NOT BE ACCEPTED UNLESS IT IS COMPLETE AND ALL SUPPORTING DOCUMENTS ARE INCLUDED!

Patient Signature: _____ Date: _____

Internal use only:

Calculations:
❑ N/A Patient Monthly Income: _____ Patient Annual Income: _____
❑ N/A Family Monthly Income: _____ Family Annual Income: _____

Other Notes:

Federal Poverty Level: _____ Approved ☐ Denied ☐

Name of Interviewer: _____ Date: _____

CONDIFENTIAL

CATHOLIC CHARITIES
DIOCESE OF ARLINGTON