INOVA

Financial Assistance Office
8095 Innovation Park Drive
Fairfax, VA 22031

Verification of Support (Residency and/or Income)

APPLICANT: This form is to be completed by the person who is helping to support you and your family by giving you food, shelter and/or money. This document does not assign to you, any financial responsibility of outstanding medical debt due from the patient who is applying for financial assistance.

The person requesting completion of this form has requested financial assistance from Inova Health System associated with services provided. This information is necessary to complete the eligibility review.

I am providing_____ and his/her family with:
(Patient / Guarantor Name)

Type of Support:
_____ **Shelter** - Move in Date: _____ Move Out Date/Present: _____
_____ **Food**
_____ **Financial Support**

Financial Support Amount: $_____Weekly $ _____Bi-Weekly $_____ Monthly
Date From: _____ Date To: _____

Name of person providing support: _____ Relationship:_____
Address of person providing support: _____

Attestation:
I certify that to the best of my knowledge, the above information is true and correct. I agree that you may contact me if further verification is necessary.

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Signature of Person Completing This Form Date Signed

<u>This Form Must Be Notarized:</u>

I, the undersigned Notary Public, certify that this document was signed before me in the City/County of _____on this _____ day of_____, 20_____.

_____
Notary Public

My commission Expires: _____