

## Verification of Support

This form is to be completed by the person who is helping to support the patient with shelter, food and living expenses. This document does not assign any financial responsibility of outstanding medical debt due from the patient who is applying for financial assistance from Inova.

**Patient:** If you have another source of funds that assists with your expenses then also provide paystubs, Verification of Employment, or Verification of Support.

**Supporter:** If you are completing this as a supporter, you must include the most recent tax return to determine if the patient is claimed as a dependent. If you do not file a tax return, provide a statement indicating that you do not file a tax return and do not declare the patient as a dependent. The patient has requested financial assistance from Inova associated for services provided. The below information is necessary to complete the eligibility review.

Patient name: \_\_\_\_\_

Type of Support (complete all sections below):

Shelter:  None or Move in date: \_\_\_\_\_ Move out date: \_\_\_\_\_ or  Still living here

Food:  None or Average monthly expenses for the patient's household \$ \_\_\_\_\_

Living expenses:  None or Average monthly expenses for the patient's household \$ \_\_\_\_\_

Name of person providing support: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address of person providing support: \_\_\_\_\_

Phone number/email 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.

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Date signed