

Virtua Charity Assistance Program

At Virtua, our mission is to provide every patient with an outstanding experience, regardless of his or her ability to pay for services. For patients who do not have health insurance and are not eligible for state or federal assistance such as Medicaid, Virtua may be able to help. Based on your income and medical needs, you may qualify for financial relief through Virtua Charity Assistance Program.

You may be eligible for a significant reduction to your hospital bill if:

- You have no insurance coverage.
- You are not eligible for Medicaid.
- You are not eligible for a 100 percent adjustment under the State of New Jersey Charity Care program.
- You are not eligible for reimbursement from any third parties such as lawsuits, employers, schools, or churches.
- The gross annual income for your household is less than \$185,000

If you meet **all** of the above criteria, please fill out the application on the back of this form and attach a copy of your latest paycheck stub or income source. Please note that financial relief applies to hospital services only. You may receive separate bills from other providers, such as physicians. Completed forms should be sent to:

Virtua Patient Accounting
2000 Crawford Place, Suite 100
Mount Laurel, NJ 08054
ATTN: Charity Assistance Program

What if I have questions?

Representatives are available toll-free at 1-800-418-5685.



Application for Virtua Charity Assistance Program

	NT INFORMATION INF	ON MI		PONSIBLE F First Name		MI	
Street Address			Street Address				
City State		Zip Code	City State		Zip Code		
Date of Birth Social	Security Number	Gender(M/F)	Date of Birth Socia	al Security Nu	mber Ger	nder(M/F)	
		INCLIDANCE	NFORMATION				
		INSURANCE I	INFORMATION	Yes	No		
1-) Are you covered une	der any health insu	rance, including fore	eign coverage?				
2-) Was treatment due t	o a work-related in	e accident?					
3-) Do you have a laws	uit or claim pending	g associated with thi	s injury or illness?				
4-) Do you have an app	lication pending for	r Medicaid or Charit	y Care?				
		e if earnings are week	FORMATION kly (W), monthly (M) or DINCOME				
•	Name of Family Member		ss of employer	Gross	Earnings	How often W M A	
-) -)							
-)						W M A	
						W M A	
Source	Amayınt	How often	INCOME Source		A manuat	How ofte	
ocial Security	Amount	W M A	Alimony	, i	Amount	W M A	
etirement Benefits		W M A	Child Support			W M A	
ensions		W M A	Other Income			W M A	
Please attach copies of Virtua Patient Account 000 Crawford Place, Mount Laurel, NJ 0803 ATTN: Charity Assistancertify that the above infontrue, Virtua may, at its or	ting Suite 100 54 ance Program rmation is true and	Applications other incom information accurate to the best	MUST be submitted to documentation. And annot be processed of my knowledge. If any	d with payon the second of the second of the second will be second or second	check stul as without l be returi	bs or this ned.	
Applicants Name (Please print)		Applic	Applicants Signature		Date		
otal Verified annual incor	me:	For Facili	ty Use Only Approved by:				