Verification of Residency

This form is to be completed by the person who is verifying residency on the patient's behalf. This document does not assign any financial responsibility of outstanding medical debt due from the patient who is applying for financial assistance from Inova.

The patient has requested financial assistance from Inova associated for services provided. The below information is necessary to complete the eligibility review.

Patient name: _____

Landlord name: _____

Landlord address:_____

Landlord Phone number: _____

Move in date: _____ Move out date: _____ or ☐ Still living here

Amount paid by patient: $_____ ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other: _____

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