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: ***Do not complete this form if you claim the patient as a dependent on your taxes.** The patient has requested financial assistance from Inova for services provided. The below information is necessary to complete the eligibility review.

Patient name:_____

Type of support provided to the patient and their family (complete all sections below):

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

Food and living expenses: Monthly expenses provided $ _____

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.

_____ _____
Typed or written signature of person completing this form Date signed