Verification of Employment

This form is to be completed by the person who is verifying income 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: _____

Frequency of pay: ☐Weekly ☐Biweekly ☐Monthly ☐Other:_____

Wages (gross - before taxes): $_____ per ☐ Week ☐ 2 weeks ☐ Month ☐ Year

Company name: _____

Company address:_____

Company phone number: _____

Name of person completing this form: _____

Person completing this form title/position: _____

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