Virginia Hospital Center
Senior Health and Lifeline

APPLICATION FOR LIFELINE BENEFITS

General Information
Virginia Hospital Center is proud of its not-for-profit mission to provide quality healthcare to all who need it. With this application, you can apply for assistance towards your monthly monitoring fee for Lifeline. Virginia Hospital Center will offer charity care based on need. All efforts will be made to establish whether the patient is eligible for charity care before Lifeline services are provided. Mail application to: 1701 N. George Mason Dr, Arlington VA 22205.

Funds will be dispersed to individuals based on their monthly net income through the Income and Eligibility Verification System (IEVS). Subscribers requesting assistance will be required to complete this application for benefits. The information that you give may be matched against Federal, State and local records.

You must give complete, accurate and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. If you knowingly give false, incorrect, or incomplete information, or fail to report changes, your application will be denied. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be reported to local authorities for fraud.

Completing the Application
If you need help completing this Application, a case manager or social worker can help you. If you and your spouse are applying, you both need to sign the application. If you are completing this application for someone else, answer each question as they relate to that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change.

Filing the Application
You may turn in the completed Application by mail, fax or bring it to Virginia Hospital Center Senior Health office. If you need help or if you have questions, please contact your local Department of Social Services (DSS) office. Upon receipt of a completed financial profile and applicable documentation, Virginia Hospital Center Senior Health and Lifeline will compare the information to the HHS Poverty Guidelines. If the patient does not provide the necessary documentation, the account will be handled as a self pay account. You have the right to turn in your Application even if it looks like you may not be eligible for benefits.

Your rights
In accordance with Federal law and U.S. Department of Agriculture policy, Virginia Hospital Center is prohibited from discriminating on the basis of race, color, national origin, sex, religious creed, disability, political benefits, or retaliation. The Virginia Hospital Center is an equal opportunity provider.

Household Information

Applicant Name (please print)		DOB
Address		Apt./Unit Number
City	State	Zip Code
Telephone	Mobile Phone	Work Phone
Employment Status	Employer	Occupation
Are you also applying for your spouse? ☐Yes ☐ No	Spouse's Name	Spouse's DOB

Please list other individuals (excluding spouse) living in your home?

1. Name _____ Does this individual pay rent? If yes, what is their monthly rent?
   Relationship _____ ☐Yes ☐ No $_____ / month

2. Name _____ Does this individual pay rent? If yes, what is their monthly rent?
   Relationship _____ ☐Yes ☐ No $_____ / month

Resources

Name of Bank	Amount in Checking $ _____	Amount in Savings $ _____
Name of Bank	Amount in Checking $ _____	Amount in Savings $ _____

Do you have any stocks, bonds, deeds of trusts, pensions, CDs, mutual funds or retirement accounts? ☐Yes ☐ No

Where is the account held?	Account Type	Amount
_____	_____	$ _____
_____	_____	$ _____

Please check the insurance plan(s) you and your spouse have (check all that apply):

☐ Medicare ☐ Medicaid (type)_____ ☐ Supplemental (Company) _____

Do you or your spouse have any life and/or long term care insurance? ☐Yes ☐ No

Policy Holder	Policy Type	Company Name	Cash/Face Value
_____	☐ Life ☐ Long Term	_____	$_____
_____	☐ Life ☐ Long Term	_____	$_____

Financial Information

Please list you and your spouse's monthly **income** (prior to deductions) from:

	You	Spouse
Social Security	$ _____	$ _____
SSI	$ _____	$ _____
Wages/Salary	$ _____	$ _____
Pensions	$ _____	$ _____
Sick Leave	$ _____	$ _____
Vacation	$ _____	$ _____
Disability	$ _____	$ _____
Self-Employment	$ _____	$ _____
Allowances	$ _____	$ _____
Other	$ _____	$ _____
Total Mo. Income:	$_____	$ _____

Please list your combined monthly **expenses** for:

Mortgage/Rent $ _____

Gas $ _____

Electricity $ _____

Water/Sewage $ _____

Telephone $ _____

Food $ _____

Cable $_____

Transportation

Fuel $ _____

Auto Ins. $ _____

Bus/Taxi $_____

Insurance

Home $_____

Medicare $_____

2nd Health $ _____

Medicare Pt. D $ _____

Medications $_____

Medical $_____
(Not covered by insurance)

Dental $_____

Other:_____ $_____

Other:_____ $_____

Other:_____ $_____

Total Mo. Expenses $_____

VHC Use Only
Reviewed by:_____

Date Received: _____

Eligibility requirements met:
☐Yes ☐ No
If yes, redetermination date:
_____

By my signature below, I declare:

- I understand all the information in the General Information section of this application.
- I understand that I must report ownership of all annuities my spouse or I have and I will report any changes in my situation to Virginia Hospital Center Lifeline.
- I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I will have my assistance revoked and could be reported to local authorities for fraud.
- I understand all information will be confidential and will be used only to determine eligibility. I agree the use of any fact pertaining to my personal life is at my risk and responsibility and that Virginia Hospital Center shall not be liable.
- **I understand that if approved for the subsidy, I am still responsible for the reduced monthly fee and equipment until services are deactivated between me and Virginia Hospital Center.**

_____ Applicant Signature or Mark

_____ Spouse Signature or Mark

_____ Date

Assigned Case Manager (please print)	Email Address	
Office Phone	Date	Signature