



Financial Assistance Office  
8095 Innovation Park Drive  
Fairfax, VA 22031

## Verification of Residency

**APPLICANT:** This form is to be completed by the person who is verifying residency on your behalf. This document does not assign to you, any financial responsibility of outstanding medical debt due from the patient who is applying for financial assistance.

The person requesting completion of this form has requested financial assistance from Inova Health System associated with services provided. This information is necessary to complete the eligibility review.

Guarantor/MRN: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Landlord Name: \_\_\_\_\_

Landlord Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Length of Residency: Move in Date: \_\_\_\_\_ Move out Date: \_\_\_\_\_

Amount Paid: \_\_\_\_\_  Weekly  Bi-Weekly  Monthly

Landlord 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

### This Form Must Be Notarized:

I, the undersigned Notary Public, certify that this document was signed before me in the City/County of \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission Expires: \_\_\_\_\_