

# FINANCIAL ASSISTANCE APPLICATION



PLACE PATIENT LABEL ABOVE THIS LINE

1. PATIENT OR APPLICANT NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ PHONE# \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_
2. WERE YOU AN OHIO RESIDENT AT THE TIME OF YOUR HOSPITAL SERVICE? \_\_\_\_\_NO \_\_\_\_\_YES
3. DID YOU HAVE, OR HAVE YOU APPLIED FOR MEDICAID / DISABILITY / INSURANCE AT THE TIME OF YOUR HOSPITAL VISIT?  
 \_\_\_\_\_NO \_\_\_\_\_YES / LIST WHICH ONE ? \_\_\_\_\_

4. LIST EACH MEMBER OF YOUR HOUSEHOLD INCLUDING YOURSELF AND EACH MEMBER'S INCOME INCLUDING YOURSELF:  
 TYPE OF INCOME TO INCLUDE: WAGES *BEFORE* TAXES, UNEMPLOYMENT, WORKERS COMP, PENSION, SOCIAL SECURITY,  
 SELF EMPLOYMENT, CHILD SUPPORT, ALIMONY, VA BENEFITS. *(IF YOU NEED ADDITIONAL SPACE, PLEASE USE BACK OF FORM)*

**\*\*PLEASE PROVIDE INCOME VERIFICATION\*\***

NAME	AGE	RELATIONSHIP	TOTAL INCOME FOR LAST 3 MONTHS	TOTAL INCOME FOR LAST 12 MONTHS	TYPE OF INCOME
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

5. IF YOU REPORTED ZERO TOTAL INCOME, HOW ARE YOU BEING SUPPORTED? \_\_\_\_\_
6. DO YOU HAVE ASSETS OVER \$10,000 (SUCH AS SAVINGS, STOCKS, BONDS, CD'S, OTHER)?  
 \_\_\_\_\_NO \_\_\_\_\_YES / LIST TYPE AND AMOUNT \_\_\_\_\_
7. BY MY SIGNATURE BELOW, I CERTIFY THE INFORMATION ON THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE, AND IF FOUND TO BE INCORRECT, MAY VOID THIS APPLICATION, AND ITS DETERMINATION MAY BE REVERSED.

**X**

APPLICANT OR GUARANTOR SIGNATURE

DATE

## STOP HERE / OFFICE USE ONLY

MED REC # / FACILITY	PROGRAM	NUMBER OF PIECES IMAGED: _____
_____MSV	_____HCAP	CONTROL NUMBER: _____ DATE: _____
_____MSC	_____HFA 200%	PATIENT NUMBER: _____ DOS: _____
_____MSA	_____HFA 300%	PATIENT NUMBER: _____ DOS: _____
_____MD	_____HFA 400%	PATIENT NUMBER: _____ DOS: _____
_____MT	_____DA	PATIENT NUMBER: _____ DOS: _____
_____MW	_____SELF PAY	SEE ATTACHED FOR ADDITIONAL PATIENT NUMBERS: _____
		HHS _____ TOTAL INCOME _____ 3MO 12MO