

FINANCIAL ASSISTANCE APPLICATION

OFFICE USE ONLY

CareNet# _____	% of Co-Pay _____	H-Cap _____	Medical Home _____
Charity _____	Start Date _____	End Date _____	

Patient's Name _____	Applicant Name _____
	(if different from patient)
Patient's SS# _____	Patient's DOB _____
Address _____	City _____ State _____ Zip _____
Phone # _____	Alternate Phone # _____
Spouse's Name _____	Spouse's DOB _____
Spouse's SS# _____	

Have you been a Lucas County resident for the past 6 months? Yes No
 United States Citizen? Yes No

Patient's Primary Care Physician: _____ Clinic Name: _____

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow/widower Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female If female & over 40 are you enrolled in BCCP? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a U.S. Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No Do you receive VA Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No

Optional:

Ethnicity: Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No Race: <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other _____ Primary Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____
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Provide information for ALL people in your immediate family who live in your home

*If zero (0) income is reported, explain how patient is supporting self _____
 *Number of people in your family: _____ If you need more space, please attach a separate sheet

Name	DOB	Relationship to patient	Adopted, Natural, Step-child	Current gross monthly income	Type of income**	Gross income 3 months prior to date of service	Gross income 12 months prior to date of service
				\$		\$	\$
				\$		\$	\$
				\$		\$	\$
				\$		\$	\$
				\$		\$	\$

**Types of income included are: wages, self employment, social security, unemployment, child support, alimony, workers' comp., pension, VA benefits, OWF, etc.

***Provide income verification with application.** Income verification may include: pay stubs, 1040 IRS tax forms, W-2's, self employment records, award letter, bank statement, etc.

PLEASE LIST ALL CURRENT EMPLOYERS

1) Are you currently employed? Yes No

Patient Current Employer(s) & Phone #(s) with start date(s) : _____

All Patient's Previous Employers in past 12 months (please list beginning and end dates):

All Spouse Employer(s) in the past 12 months (please list beginning and end dates): _____

2) Have you applied for Medicaid or Disability Assistance? Yes No.....if Yes,
What were the results? _____ Billing # _____

3) Do you have health insurance (other than Medicaid)? Yes No.....if Yes,
List type of insurance _____ Policy # _____ Group# _____

4) Do you now, or have you in the past, had a workman's comp claim? Yes No If Yes,
Date _____ Claim # _____ Medical Problem _____

Are you still receiving benefits Yes No Medical Treatment _____

5) Were you an Ohio resident at the time of hospital service Yes No

6) Please indicate if any of the outstanding medical bills with our facilities are due to a Motor Vehicle accident or due to Liability? Yes No.....if Yes, please complete the following section:

Name of Auto Insurance _____

Insurance Address _____

Policy Number _____

Insurance Agent's Name/Phone _____

Name of person liable for accident _____

7) Do you have assets over \$10,000 such as savings, checking, home equity, stocks, bonds, 401, IRA, CD's, etc?

Yes No If Yes, list type and amount _____

I have read and understand the **Notice of Privacy Practice**: Yes No

I understand any financial assistance provided may be reversed if it is determined this information is not correct.

"Providing false information to induce another to extend credit or to bestow any other valuable benefit may be a violation of the Ohio Revised Code Section 2921.13".

By my signature below, I affirm the information on this application is true to the best of my knowledge.

Signature of patient

Date

Signature of spouse

Date

Signature of enrollment coordinator

Date

Medicaid Application Confirmation Number

Date of Medicaid Application