Application for Financial Assistance

1.) Date of service: ______________________________

2.) Patient's Name: ______________________________ **3.)** SSN: ____________________

4.) Patient's Address: ____

City: ____________________ State: ______ ZIP: _________ Phone: ________________

5.) On the date of service listed above, was the patient a resident of Ohio? ___ **Yes** ___ **No**

6.) Did the patient have health coverage(s) on the date of service above? ___ **Yes** ___ **No**

If you answered "Yes," please include a copy of your insurance card(s) with your application.

7.) List the patient's **HOUSEHOLD MEMBERS** and **TOTAL BEFORE-TAX INCOME** received by each prior to the **DATE OF SERVICE** above.

Q. Who is in my "household?"

A. For an **adult patient**, household is limited to the patient, patient's spouse (even if living apart) and patient's biological or legally adopted children under 18 who live in the same home as the patient.

For a **minor patient**, household is limited to the patient, patient's mother, patient's father and patient's siblings under 18. Both parents must be listed on this application, even if they do not live together.

Q. What does the State of Ohio consider "income?"

A. Income is considered to be total before-tax salaries, wages and cash receipts, including employment, unemployment , Social Security (before deductions), VA benefits, alimony, child support, worker's compensation, pension / retirement income, OWF assistance and self-employment or odd job income. Food stamps are not counted as income, but should be listed on "Support Statement" line below.

Name	Relation to Patient	Age	Total Income in the 3 Months Prior to DATE OF SERVICE	Total Income in the 12 Months Prior to DATE OF SERVICE	Income Source
	Self				

8.) Support Statement:

IF YOU ATTESTED THAT NO INCOME WAS RECEIVED in this household in the 3 months prior to the date of service, you must state how the household was supported while zero income:

____

____

Patient's Signature: ______________________________ **Date:** ________________

Applicant's Signature (if not Patient): ____________________ Relation to Patient: ________________

CERTIFICATION: By signing this document, I affirm the answers on this application are true and I understand that it is unlawful to knowingly submit false information to obtain government benefits. Should a subsequent review of an individual's financial aid application reveal that information provided by the individual was either incorrect or fraudulent, the decision to provide financial aid may be reversed and the responsible party will be billed.