FINANCIAL ASSISTANCE APPLICATION

DATE OF SERVICE: _____ ACCOUNT NUMBER: _____

PATIENT OR APPLICANT NAME: _____

ADDRESS: _____

CITY: _____STATE: _____ ZIP:_____

PHONE:_____MARITAL STATUS:_____

THE FOLLOWING <u>MUST</u> BE COMPLETED FOR FINANCIAL ASSISTANCE CONSIDERATION. PLEASE NOTE UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE.

(List spouse and dependent children under 18 year, living in the household and their dates of birth)

NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	TOTAL GROSS INCOME IN THE 3 MONTHS PRIOR TO THE DATE OF SERVICE	TOTAL GROSS INCOME IN THE 12 MONTHS PRIOR TO THE DATE OF SERVICE	SOURCE OF INCOME EMPLOYER NAME (STATE IF YOU ARE A COLLEGE STUDENT)
	SELF				

1. **IF YOU REPORTED ZERO TOTAL INCOME, HOW ARE YOU BEING SUPPORTED? _____**
2. WHAT STATE DID YOU RESIDE IN AT THE TIME OF YOUR VISIT? _____
3. HAVE YOU APPLIED FOR MEDICAID OR ANY OTHER COUNTY ASSISTANCE? ☐ NO ☐ YES (DATE/STATE_____)
4. DID YOU HAVE HEALTH INSURANCE ON THE DATE OF SERVICE? ☐ NO ☐ YES (PROVIDE COPY OF CARD WITH THIS APPLICATION)
5. WAS THE DATE OF SERVICE RELATED TO AN AUTO ACCIDENT? ☐ NO ☐ YES (INSURANCE NAME/CLAIM#_____)
6. DOES ANYONE IN YOUR HOME HAVE A CHECKING OR SAVINGS ACCOUNT? ☐ NO ☐ YES (VALUE_____)
7. DOES ANYONE IN YOUR HOME HAVE ANY OTHER ASSETS? ☐ NO ☐ YES (TYPE/VALUE)_____)
8. DO YOU OWN OR RENT A HOME? ☐ OWN ☐ RENT ☐ OTHER (_____)

FOR INCOME ASSETS LISTED ABOVE YOU MUST PROVIDE THE FOLLOWING FOR EACH MEMBER OF THE HOUSEHOLD:

(please check items received)

- ☐ EMPLOYMENT = 3 OR 12 MONTH INCOME
- ☐ UNEMPLOYMENT = BENEFIT LETTER
- ☐ SOCIAL SECURITY = BENEFIT LETTER
- ☐ PENSION OR DISABILITY= BENEFIT LETTER
- ☐ SELF EMPLOYMENT = COMPLETE TAX FORMS INCLUDING SCHEDULE C
- ☐ CHILD SUPPORT = COURT ORDERED DOCUMENT
- ☐ OTHER= PROOF OF ANY OTHER INCOME SUCH AS DIVIDENDS, INTEREST, RENTAL INCOME
- ☐ CHECKING / SAVINGS = CURRENT 30 DAY STATEMENT FOR EACH ACCOUNT

CERTIFICATION: *BY SIGNING THIS DOCUMENT, I AFFIRM THE ANSWERS ON THIS APPLICATION ARE TRUE. SHOULD A SUBSEQUENT REVIEW OF AN INDIVIDUAL'S FINANCIAL ASSISTANCE APPLICATION REVEAL THAT INFORMATION PROVIDED BY THE INDIVIDUAL WAS EITHER INCORRECT OR FRAUDULENT, THE DECISION TO PROVIDE FINANCIAL ASSISTANCE MAY BE REVERSED AND THE RESPONSIBLE PARTY WILL BE BILLED. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY MY HOSPITAL PROVIDER, INCLUDING CREDIT REPORTING AGENCIES, AND SUBJECT TO REVIEW BY FEDERAL AND/OR STATE AGENCIES AND OTHERS AS REQUIRED.*

PATIENT SIGNATURE: _____ **DATE:** _____

APPLICANT OR REPRESENTATIVE SIGNATURE:_____**RELATIONSHIP:**_____**DATE:**_____
(IF NOT PATIENT)

MAIL COMPLETED APPLICATION AND DOCUMENTATION TO:
Mercy Health Public Benefits Dept
PO Box 631774
Cincinnati, OH 45263-1774

Last Revision: 03/2024