APPLICATION FOR ASSISTANCE

F-0417-NS 905 0720

PATIENT NAME & SOCIAL SECURITY NUMBER	AGE	# IN FAMILY	MARITAL STATUS	SPOUSE/PARENT/OTHER	PHONE

PATIENT ADDRESS	CITY, STATE, ZIP	PATIENT EMPLOYER	HOW LONG?

GUARANTOR & SOCIAL SECURITY NO.	GUARANTOR ADDRESS	GUARANTOR EMPLOYER	HOW LONG?

WERE YOU AN ACTIVE MEDICAID RECIPIENT AT THE TIME OF YOUR HOSPITAL SERVICE? YES____________ NO ___________________	CHECKING _______________ BALANCE _______________ OTHER ASSETS _______________ SAVINGS _______________ BALANCE _______________ BANK _______________________

WERE YOU AN OHIO RESIDENT AT THE TIME OF YOUR HOSPITAL SERVICE? Y_____________ N_____________	DID YOU HAVE HEALTH INSURANCE(OTHER THAN MEDICAID) AT THE TIME OF YOUR HOSPITAL SERVICE Y_______ N________	RENT_________BUYING ______ OWN_______ C/O RELATIVES_______	MORTGAGE BALANCE /PROPERTY VALUE

FAMILY MEMBERS

NAME	AGE	DOB	RELATIONSHIP/SSN	INCOME

GROSS INCOME

(Please include copies of income either 3 or 12 months prior to date(s) of service.)

PATIENT	UNEMP	WORKERS COMP
SPOUSE	PENSION	OTHER
SOC. SECURITY	CHILD SUPPORT	

BASIC MONTHLY EXPENSES

*(in the event that you would not qualify for HCAP and would like to be considered for internal charity, Please **include copies** of your **monthly expenses.)***

HOUSING	WATER	CHILD CARE
GAS	ELECTRIC	
CABLE	PHONE	

DATES OF HOSPITAL SERVICE

ACCOUNT NUMBER______________________________ DATE OF SERVICE FROM __________TO_____________ BALANCE_____________________

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ACCOUNT NUMBER______________________________ DATE OF SERVICE FROM __________TO_____________ BALANCE_____________________

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNED___________________________________ *OR* _______________________________________ ____________________ _____________

SIGNATURE OF PERSON COMPLETING FORM *RELATIONSHIP* *DATE*

OFFICE USE ONLY

SIGNED____ DATE_________________ Approved for____________________

DIRECTOR/MANAGER, PATIENT ACCOUNT SERVICES

ADDITIONAL FAMILY MEMBER INFORMATION

Name	Relationship	Birthdate	Soc. Sec. #	Monthly Income

“Family” shall include the PATIENT, THE PATIENT’S SPOUSE, AND ALL OF THE PATIENT’S CHILDREN, natural or adoptive, under the age of eighteen who live in the home, IF THE PATIENT IS UNDER THE AGE OF EIGHTEEN, THE “FAMILY” SHALL INCLUDE THE PATIENT, THE PATIENT’S NATURAL OR ADOPTIVE PARENT(S)’, AND THE PARENT(S)’ CHILDREN, NATURAL OR ADOPTIVE UNDER THE AGE OF EIGHTEEN WHO LIVE IN THE HOME.

ADDITIONAL COMMENTS