Lindner Center of HOPE | UC Health

PLEASE RETURN TO THIS HOSPITAL'S FINANCIAL COUNSELOR OR MAIL TO:
4075 Old Western Row Road
Mason, Ohio 45040
513-536-HOPE (4673)

FINANCIAL ASSISTANCE APPLICATION

Please use black or blue ink.

Date of Service: _____

Account Number: _____

Patient Name: _____ **Phone: (** _____ **)** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Applicant Name: _____ **Relationship to Patient:** _____

Please answer the following questions as they apply to this patient:

Were you an Ohio, Kentucky or Indiana resident at the time of your hospital service? ☐ Yes ☐ No

Were you receiving Medicaid at the time of your hospital service? ☐ Yes ☐ No

If yes, Medicaid recipient ID number is:

Were you receiving Disability Assistance at the time of your hospital visit? ☐ Yes ☐ No

If yes, Disability Assistance ID number is:

Did you have any other health insurance at the time of your hospital service? ☐ Yes ☐ No

If yes, please provide a copy of your card.

Income verification must accompany this application. Documentation must be received within 45 days in order to process your application. Please include proof of gross income for the last three months or 12 months prior to service. If you report $0 income, please explain below with the beginning and end dates of your unemployment. Must supply separated spouse's income or a detailed statement as to why you cannot provide the information.

Please provide the following for all of the people in your immediate family. This is defined as the patient, the patient's spouse, and all of the patient's children under 18 (biological or adoptive). Please add additional sheets of paper if needed.

Name(s)	*Date of Birth*	*Relationship to patient*	*Income total for 3 months before service*	*Income total for 12 months before service*	*Type of income verification attached*

DO YOU OR YOUR FAMILY MEMBERS RECEIVE INCOME FROM ANY OTHER SOURCE? ☐ Yes ☐ No

If so, please note amount: _____

IF YOU ARE REPORTING ZERO INCOME, PLEASE COMPLETE THE FOLLOWING:

I, (patient/applicant name) _____ , have had no income from _____ (date) through _____ (date) prior to date of service. Please explain your living situation and how you have been supporting yourself and your family during this time.

_____

_____

_____

_____

By my signature below, I certify that everything I have stated on this application and in my attachments is true.

Signature (patient/applicant): _____ Date: _____

Must be signed and dated to be valid

Please note this applies only to services received at Lindner Center of HOPE.