

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 if not already provided: _____

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 pay periods for each employer in the current year and a copy of page 1 of the most recent 1040 federal return. If you receive income from another source, such as child support, alimony, social security, pension, etc., please provide documentation of the amount and frequency of payment. 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, adoptive or step-children). 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

Please indicate if you or your family members:

Receive income from another source: Yes No \$ _____

Own or rent a home: Yes No monthly payment \$ _____

Checking/Savings: Yes No \$ _____

Other assets, including money market/stocks: Yes No \$ _____

If you reported zero income, how are you being supported? _____

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.*