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 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 note, families who are members of an insurance plan that is not contracted with Lindner Center of HOPE will not be eligible for the discount on the unpaid portion of their claim. They will only be eligible for the discount on the balances attributed to deductibles and/or co-insurance. Also note that discounts may not apply if a Health Savings Account (HSA), Health Reimbursement Account (HRA) or similar fund designated for family medical expenses has been established. Payment from either fund is due before any discount can apply.

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.