How to apply for Financial Assistance through the Lindner Center of HOPE and Lindner Center of Hope Professional Associates

Please complete, sign and date the financial assistance application. If at any point in the application process you have a question, please call 513-536-0224 and speak to one of our Financial Counselors.

Please note that an application is not considered complete and will not be processed <u>unless</u> all information requested is received. Incomplete applications will automatically be denied 45 calendar days after the date of the signed application. Below is a list of acceptable documentation to accompany your financial application. Financial Assistance will not be considered for no-show fees nor balances already in collections.

- Provide proof of <u>household</u> income for the 12 month period prior to your date of service, including your most recent pay advices. Examples of acceptable documentation include:
 - Tax return Front page and the Schedule 1 of the previous year's tax return. If you are claiming to be Self-Employed, provide signed attestation of income and most recent copy of Tax Schedule C.
 - Pay Stubs From all employers for the current year.
 - Social Security Award letter(s) From the previous and current year.
 - Pension From the previous and current year.
 - Unemployment Compensation Award letters with names and dates
 - Court Support order
 - Letter from your employer, on official employer letterhead, setting forth compensation details. Must include employer contact information.
 - Zero income If the patient is reporting zero income for any length of time
 12 months prior to the date of service, please complete the Support
 Statement near the end of the financial assistance application.
- **Proof of Residency** at the time of your date of service at the Lindner Center of Hope. Examples of acceptable documentation include:
 - Driver's license
 - Vehicle registration
 - Voter registration matching address at the time of service
 - Rent receipts for rent paid within 60 days of when services are rendered.
 - Mortgage statement
 - Utility bill
 - Credit card or bank statement postmarked or date by the issued within 60 days of when services are rendered
 - Letter from lease management, mortgage company, or person providing the patient with shelter, including homeless shelters.
- **Proof of Insurance** Health Spending Account (HSA) or Health Reimbursement Account (HRA) and Flexible Spending Account (FSA).
 - Current HSA/HRA/FSA statements, if applicable.

Please return completed, signed, and dated application with supporting documentation directly to the Welcome Center or by ONE of the following:

Mail to: Lindner Center of Hope Email to: Lcoh-financial-assistance@lindnercenter.org

Attn: Financial Counseling

4075 Old Western Row Road FAX: 513-536-0239

Mason, Ohio 45040



PLEASE RETURN TO THIS HOSPITAL'S FINANCIAL COUNSELOR OR MAIL TO:

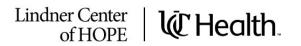
4075 Old Western Row Road Mason, Ohio 45040

513-536-HOPE (4673)

Office Hours: 8am to 6 pm M-F

LCOH-Financial-Assistance@LindnerCenter.org

Date of Service:	Account Number:				
Patient Name:					
Date of Birth:	Phone:()			
Street Address*:					
City:			Zip	:	
Email:					
Marital Status:		ouse:			
Applicant Name:					
*Proof of residency is required. Please refer to the cover lette	r for a list of a	cceptable do	cuments	i.	
Please answer the following questions as they apply to this	patient at the	ir <u>time of se</u> ı	<u>vice</u> . Ple	ease cir	cle, yes or no. If
not applicable, please circle no.					
Were you an Ohio resident at the time of your hospital service?			Yes	No	
Were you receiving Medicaid at the time of your hospital service	e?		Yes	No	
If yes, Medicaid recipient ID number is:					
Were you receiving Disability Assistance at the time of your h	ospital visit?		Yes	No	
If yes, Disability Assistance ID number is:					
Did you have any other health insurance at the time of your hos	pital service?		Yes	No	
If yes, please provide a copy of your card if not already p	rovided				
If you have other health insurance, do you have a Health Savir	igs Account or	Health Reiml	oursemer	nt Acco	unt or similar fund
designated for family Medical expenses?			Yes	No	
If yes, please provide a copy of your most recent statem	ent.				
Please note, families who are members of an insurance plan the eligible for the discount on the unpaid portion of their claim. attributed to deductibles and/or co-insurance. Also note that Health Reimbursement Account (HRA) and Flexible Spending A expenses has been established. Payment from either fund is described.	They will only discounts may ccount (FSA) o	be eligible for not apply if or similar fund	or the dis a Health d designa	count o	n the balances Account (HSA),
HOUSEHOLD INFORMATION					
Please provide the following for all of the people in your household. Figure patient's children under 18 (biological, adoptive, or step-children). Please provide the following for all of the people in your household.					spouse, and all of the
Name(s) Date	of Birth				Relationship to patient
					patient



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INCOME INFORMATION

Please provide income information for all family members including: gross (pretax wages), unemployment, social security, pension, child support, rental income or any income for all applicable members in your household. Proof is required for this application to be considered complete. Refer to the cover page for a list of acceptable documentation.

Name(s)	Last date worked	Source of Income	Income total for 3 months before service	Income total for 12 months before service
patient				
	CHIDDOL	OT CTATEMENT		
f you reported zero incom	supports of the following:	RT STATEMENT		
,(patient name)		_, have had no inco	ome for the following o	lates beginning 12 mont
orior to my time of service	e: (list starting and ending dates)			
Please explain your living	situation and how you are financia	ally supporting your	rself:	
	If you have experienced a recent hange to be included with your ap			ay include a written
N	ortion of the application is i			
application. Incomple igned application. By my signature below, I ce	ertify that everything I have stated of come or financial status will result i			
application. Incompleting igned application. By my signature below, I centry misrepresentation of incompleting professional services.		in the applicant assu	uming the responsibility	
application. Incompleting igned application. By my signature below, I centry misrepresentation of incompleting professional services. ignature (patient/applicant)	come or financial status will result i	in the applicant assu	uming the responsibility	of full payment of hospit

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IP Services_OP Services_

__90 days from review:_