

# FINANCIAL ASSISTANCE APPLICATION

DATE OF SERVICE: \_\_\_\_\_

ACCOUNT NUMBER: \_\_\_\_\_

PATIENT OR APPLICANT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

**THE FOLLOWING MUST BE COMPLETED FOR FINANCIAL ASSISTANCE CONSIDERATION. PLEASE NOTE UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE.**

(List spouse and dependent children under 18 year, living in the household and their dates of birth)

NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	TOTAL GROSS INCOME IN THE 3 MONTHS PRIOR TO THE DATE OF SERVICE	TOTAL GROSS INCOME IN THE 12 MONTHS PRIOR TO THE DATE OF SERVICE	SOURCE OF INCOME EMPLOYER NAME (STATE IF YOU ARE A COLLEGE STUDENT)
	SELF				

1. IF YOU REPORTED ZERO TOTAL INCOME, HOW ARE YOU BEING SUPPORTED? \_\_\_\_\_

2. WHAT STATE DID YOU RESIDE IN AT THE TIME OF YOUR VISIT? \_\_\_\_\_

3. HAVE YOU APPLIED FOR MEDICAID OR ANY OTHER COUNTY ASSISTANCE?     NO     YES (DATE/STATE \_\_\_\_\_)

4. DID YOU HAVE HEALTH INSURANCE ON THE DATE OF SERVICE?     NO     YES (PROVIDE COPY OF CARD WITH THIS APPLICATION)

5. WAS THE DATE OF SERVICE RELATED TO AN AUTO ACCIDENT?     NO     YES (INSURANCE NAME/CLAIM# \_\_\_\_\_)

6. DOES ANYONE IN YOUR HOME HAVE A CHECKING OR SAVINGS ACCOUNT?     NO     YES (VALUE \_\_\_\_\_)

7. DOES ANYONE IN YOUR HOME HAVE ANY OTHER ASSETS?     NO     YES (TYPE/VALUE) \_\_\_\_\_

8. DO YOU OWN OR RENT A HOME?     OWN     RENT     OTHER ( \_\_\_\_\_)

**FOR INCOME ASSETS LISTED ABOVE YOU MUST PROVIDE THE FOLLOWING FOR EACH MEMBER OF THE HOUSEHOLD:**

(please check items received)

- |   |  |
|---|--|
| <input type="checkbox"/> EMPLOYMENT = 3 OR 12 MONTH INCOME<br><input type="checkbox"/> UNEMPLOYMENT = BENEFIT LETTER<br><input type="checkbox"/> SOCIAL SECURITY = BENEFIT LETTER<br><input type="checkbox"/> PENSION OR DISABILITY= BENEFIT LETTER | <input type="checkbox"/> SELF EMPLOYMENT = COMPLETE TAX FORMS INCLUDING SCHEDULE C<br><input type="checkbox"/> CHILD SUPPORT = COURT ORDERED DOCUMENT<br><input type="checkbox"/> OTHER= PROOF OF ANY OTHER INCOME SUCH AS DIVIDENDS, INTEREST, RENTAL INCOME<br><input type="checkbox"/> CHECKING / SAVINGS = CURRENT 30 DAY STATEMENT FOR EACH ACCOUNT |
|---|--|

**CERTIFICATION:** BY SIGNING THIS DOCUMENT, I AFFIRM THE ANSWERS ON THIS APPLICATION ARE TRUE. SHOULD A SUBSEQUENT REVIEW OF AN INDIVIDUAL'S FINANCIAL ASSISTANCE APPLICATION REVEAL THAT INFORMATION PROVIDED BY THE INDIVIDUAL WAS EITHER INCORRECT OR FRAUDULENT, THE DECISION TO PROVIDE FINANCIAL ASSISTANCE MAY BE REVERSED AND THE RESPONSIBLE PARTY WILL BE BILLED. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY MY HOSPITAL PROVIDER, INCLUDING CREDIT REPORTING AGENCIES, AND SUBJECT TO REVIEW BY FEDERAL AND/OR STATE AGENCIES AND OTHERS AS REQUIRED.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

APPLICANT OR REPRESENTATIVE SIGNATURE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ DATE: \_\_\_\_\_  
(IF NOT PATIENT)

MAIL COMPLETED APPLICATION AND DOCUMENTATION TO:  
 Mercy Health Public Benefits Dept  
 PO Box 631774  
 Cincinnati, OH 45263-1774