



Financial Assistance Application

OFFICE USE ONLY

MED REC # / FACILITY	PROGRAM	CONTROL NUMBER: _____
_____ SVMMC	_____ HCAP	WRITE OFF DATE: _____
_____ SCMH	_____ HFA 200%	NUMBER OF PIECES IMAGED: _____
_____ SAMH	_____ HFA 300%	PATIENT NUMBER: _____ DOS: _____
_____ DMH	_____ HFA 400%	PATIENT NUMBER: _____ DOS: _____
_____ MHT	_____ SELF PAY	PATIENT NUMBER: _____ DOS: _____
_____ MHW	_____ CARENET	PATIENT NUMBER: _____ DOS: _____
_____ ACH	_____ DA	PATIENT NUMBER: _____ DOS: _____
_____ RMC	_____ CATASTROPHIC	SEE ATTACHED FOR ADDITIONAL PATIENT NUMBERS: _____

PATIENT INFORMATION

PATIENT OR APPLICANT'S NAME: _____		
ADDRESS: _____		
CITY: _____	STATE: _____	ZIP: _____
SOCIAL SECURITY NUMBER: _____		PHONE NUMBER: _____

EMPLOYMENT INFORMATION

NAME OF EMPLOYER (PATIENT/GUARANTOR): _____	
DATE HIRED: _____	DATE EMPLOYMENT ENDED: _____
NAME OF EMPLOYER (SPOUSE): _____	
DATE HIRED: _____	DATE EMPLOYMENT ENDED: _____
IF ZERO INCOME IS REPORTED PROVIDE EXPLANATION OF HOW PATIENT IS SUPPORTING SELF:	

HOUSEHOLD INFORMATION

*FAMILY INCLUDES IMMEDIATE FAMILY WHO LIVE IN YOUR HOME SUCH AS PATIENT, PATIENT'S SPOUSE, ALL OF PATIENT'S CHILDREN UNDER 18 (NATURAL OR ADOPTIVE) WHO LIVE IN PATIENT'S HOME. PATIENTS UNDER 18 INCLUDE PARENTAL INCOME.
ADDITIONAL FAMILY MEMBERS MAY BE INCLUDED ON A SEPARATE SHEET AND ATTACHED TO APPLICATION.

NAME	AGE	RELATIONSHIP TO PATIENT*	GROSS INCOME 3 MONTHS PRIOR TO DATE OF SERVICE	GROSS INCOME 12 MONTHS PRIOR TO DATE OF SERVICE	CURRENT GROSS INCOME	TYPE OF INCOME**
TOTAL HHS		TOTAL INCOME	\$ _____	\$ _____	\$ _____	

**TYPES OF INCOME INCLUDED BUT NOT LIMITED TO: WAGES, SELF EMPLOYMENT, SOCIAL SECURITY, UNEMPLOYMENT, CHILD SUPPORT, ALIMONY, WORKERS COMP, PENSION, VA BENEFITS.
PLEASE PROVIDE INCOME VERIFICATION WITH THIS APPLICATION: PAY STUBS, W-2'S, SELF-EMPLOYMENT RECORDS, AWARD LETTER, BANK STATEMENT SHOWING DIRECT DEPOSIT, OR ANY DOCUMENT CONTAINING INCOME INFORMATION.

PROGRAM ELIGIBILITY

HAVE YOU APPLIED FOR MEDICAID OR DISABILITY ASSISTANCE? YES _____ NO _____

IF YES, WHAT WERE THE RESULTS? _____ BILLING NUMBER: _____

WERE YOU AN OHIO RESIDENT AT THE TIME SERVICES WERE PROVIDED? YES _____ NO _____

DO YOU HAVE ASSETS OVER \$10,000 SUCH AS SAVINGS, CHECKING, STOCKS, BONDS, CD'S, OR OTHER? YES _____ NO _____

IF YES, PLEASE LIST TYPE AND AMOUNT: TYPE _____ AMT _____

INSURANCE INFORMATION

DID YOU HAVE HEALTH INSURANCE AT THE TIME SERVICES WERE PROVIDED? YES _____ NO _____

INSURANCE NAME: _____

INSURANCE BILLING ADDRESS: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

POLICY HOLDER NAME: _____

POLICY HOLDER DATE OF BIRTH: _____ POLICY HOLDER SOCIAL SECURITY #: _____

MOTOR VEHICLE ACCIDENT INFORMATION

ARE ANY MEDICAL BILLS DUE TO A MOTOR VEHICLE ACCIDENT? YES _____ NO _____

NAME OF AUTO INSURANCE: _____

AUTO INSURANCE BILLING ADDRESS: _____

POLICY NUMBER: _____

NAME OF PERSON LIABLE FOR ACCIDENT: _____

LOCATION OF ACCIDENT: _____

NAME OF RESPONDING LAW ENFORCEMENT: _____

AGENT NAME: _____ PHONE NUMBER: _____

ATTORNEY NAME: _____ PHONE NUMBER: _____

WORKER'S COMP INFORMATION

IS THIS A WORK RELATED INJURY? YES _____ NO _____

IF YES HAVE YOU FILED A WORKERS COMP CLAIM? YES _____ NO _____

WHAT IS THE CLAIM NUMBER? _____

ESTATE INFORMATION

IS THERE AN ESTATE PENDING? YES _____ NO _____

EXECUTOR NAME: _____ PHONE NUMBER: _____

ATTORNEY NAME: _____ PHONE NUMBER: _____

PLEASE ATTACH COPY OF COURT APPOINTED PAPERS

SIGNATURE

I UNDERSTAND ANY FINANCIAL ASSISTANCE PROVIDED BY COMMUNITY HEALTH PARTNERS AND ALLEN COMMUNITY HOSPITAL MAY BE REVERSED IF IT IS DETERMINED THIS INFORMATION IS NOT CORRECT. "PROVIDING FALSE INFORMATION TO INDUCE ANOTHER TO EXTEND CREDIT OR TO BESTOW ANY OTHER VALUABLE BENEFIT MAY BE A VIOLATION OF THE OHIO REVISED CODE SECTION 2921.13".

BY MY SIGNATURE BELOW I AFFIRM THE INFORMATION ON THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARANTOR _____ DATE _____ SIGNATURE OF SPOUSE _____ DATE _____