

ANDERSON \_\_\_ CLERMONT \_\_\_ FAIRFIELD \_\_\_ Mt. AIRY \_\_\_ W. HILLS \_\_\_

PATIENT NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

Applicant Name (if not patient) \_\_\_\_\_

Please use black or blue ink.

Date of Hospital Service: \_\_\_\_\_ Account Number: \_\_\_\_\_

Street Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Please answer the following questions as they apply to the patient:**

- 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? 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.

Please list all "family" members (including yourself). Family is defined as the patient, the patient's spouse (regardless of where they reside), and all of the patient's children under 18 (biological or adoptive) who live in the patient's home. Please add additional sheets of paper if needed.

Family Members	Age	Relationship to Patient	Income 3 months prior to date of service	Income 12 months prior to date of service	Income 3 months prior to date of application	Income 12 months prior to date of application	Type of Income Verification

Do you or your family members receive income from any other source? Yes      No  
 If so, please note amount: \_\_\_\_\_

If any of the family members had no income during the above time periods, please mark "NONE" as the income source and place \$0.00 as the income. If you report a total of no income, please provide a brief explanation below or on a separate piece of paper of how you (or the patient) survived financially during the above time period.

\_\_\_\_\_

Should a subsequent review of an individual's financial aid application reveal that information provided by the individual was either incorrect or fraudulent, the decision to provide financial aid may be reversed and the responsible party will be billed.

**CERTIFICATION:** By signing this document, I affirm that the answers on this application are true and I understand that it is unlawful to knowingly submit false information to obtain government benefits

Signature (patient/applicant) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Mailed application to patient for signature. Please sign and return in envelope provided.

## FEDERAL POVERTY GUIDELINES

Effective January 23, 2009

Family Size	100% FPG	150% FPG	200% FPG	300% FPG	400% FPG	More than 400% FP
1	\$10,830	\$16,245	\$21,660	\$32,490	\$43,320	Self-pay only eligible for 40% discount
2	\$14,570	\$21,855	\$29,140	\$43,710	\$58,280	
3	\$18,310	\$27,465	\$36,620	\$54,930	\$73,240	
4	\$22,050	\$33,075	\$44,100	\$66,150	\$88,200	

\*\*For a family size larger than four, add \$3,740 to the income for each additional family member

**PLEASE MAIL COMPLETED APPLICATION TO:**  
 MERCY HEALTH PARTNERS  
 4600 McAuley Place, Pt Financial Services, 5th Floor  
 Cincinnati, Ohio 45242

MHP STAFF USE ONLY	
<b>ORAL DECLARATION:</b>	
I certify that the information on the preceding page has been read to the patient or representative, answers recorded based on the applicant's responses and oral certification that the information is true and correct.	
_____ <b>Signature of Hospital Representative</b>	_____ <b>Date</b>
<b>PROOF OF INCOME PROVIDED:</b>	
Payroll Stubs _____	Letter from Social Security _____
Employee Letter or Printout _____	Other _____
<b>COMMENTS/CALCULATIONS:</b>	
APPROVE _____      DENY _____      HCAP 100% _____ HFA      100% _____      58% _____	
Financial Counselor Approval: _____	Date: _____
Manager Approval: _____	Date: _____
Director Approval: _____	Date: _____
VP Approval: _____	Date: _____
CFO Approval: _____	Date: _____