

# APPLICATION FOR ASSISTANCE

F-0417-NS 905 0720

PATIENT NAME & SOCIAL SECURITY NUMBER		AGE	# IN FAMILY	MARITAL STATUS	SPOUSE/PARENT/OTHER	PHONE
PATIENT ADDRESS		CITY, STATE, ZIP		PATIENT EMPLOYER		HOW LONG?
GUARANTOR & SOCIAL SECURITY NO.		GUARANTOR ADDRESS		GUARANTOR EMPLOYER		HOW LONG?
WERE YOU AN ACTIVE MEDICAID RECIPIENT AT THE TIME OF YOUR HOSPITAL SERVICE? YES _____ NO _____			CHECKING _____ BALANCE _____ OTHER ASSETS _____ SAVINGS _____ BALANCE _____ BANK _____			
WERE YOU AN OHIO RESIDENT AT THE TIME OF YOUR HOSPITAL SERVICE? Y _____ N _____		DID YOU HAVE HEALTH INSURANCE(OTHER THAN MEDICAID) AT THE TIME OF YOUR HOSPITAL SERVICE Y _____ N _____		RENT _____ BUYING _____ OWN _____ C/O RELATIVES _____		MORTGAGE BALANCE /PROPERTY VALUE
<b>FAMILY MEMBERS</b>						
NAME		AGE	DOB	RELATIONSHIP/SSN		INCOME
<b>GROSS INCOME</b> (Please include copies of income either 3 or 12 months prior to date(s) of service.)						
PATIENT		UNEMP			WORKERS COMP	
SPOUSE		PENSION			OTHER	
SOC. SECURITY		CHILD SUPPORT				
<b>BASIC MONTHLY EXPENSES</b> (in the event that you would not qualify for HCAP and would like to be considered for internal charity, Please include copies of your <i>monthly expenses</i> .)						
HOUSING		WATER			CHILD CARE	
GAS		ELECTRIC				
CABLE		PHONE				
<b>DATES OF HOSPITAL SERVICE</b>						
ACCOUNT NUMBER _____		DATE OF SERVICE FROM _____		TO _____		BALANCE _____
ACCOUNT NUMBER _____		DATE OF SERVICE FROM _____		TO _____		BALANCE _____
ACCOUNT NUMBER _____		DATE OF SERVICE FROM _____		TO _____		BALANCE _____
ACCOUNT NUMBER _____		DATE OF SERVICE FROM _____		TO _____		BALANCE _____
THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.						
SIGNED _____ OR _____ SIGNATURE OF PERSON COMPLETING FORM RELATIONSHIP DATE						
<b>OFFICE USE ONLY</b>						
SIGNED _____ DATE _____ Approved for _____ DIRECTOR/MANAGER, PATIENT ACCOUNT SERVICES						

## ADDITIONAL FAMILY MEMBER INFORMATION

Name	Relationship	Birthdate	Soc. Sec. #	Monthly Income
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[illegible]

"Family" shall include the PATIENT, THE PATIENT'S SPOUSE, AND ALL OF THE PATIENT'S CHILDREN, natural or adoptive, under the age of eighteen who live in the home, IF THE PATIENT IS UNDER THE AGE OF EIGHTEEN, THE "FAMILY" SHALL INCLUDE THE PATIENT, THE PATIENT'S NATURAL OR ADOPTIVE PARENT(S)', AND THE PARENT(S)' CHILDREN, NATURAL OR ADOPTIVE UNDER THE AGE OF EIGHTEEN WHO LIVE IN THE HOME.

## ADDITIONAL COMMENTS

[illegible]