

SUBMITTED BY: \_\_\_\_\_



## FINANCIAL ASSISTANCE SCREENING APPLICATION

All of the following information must be completed.

Patient Name \_\_\_\_\_ Phone \_\_\_\_\_

Complete Address \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Account Number(s) \_\_\_\_\_

Date(s) of Service \_\_\_\_\_

- you must apply within 6 months of the date of service or date of first bill for hospital financial assistance

Were you a resident of Ohio at the time of service?	<b>Yes or No</b>	Are you currently a resident in Ohio?	<b>Yes or No</b>
Are you residing in Ohio for the sole purpose of receiving health care?	<b>Yes or No</b>		
Were you an active recipient of Disability Assistance at the time of your hospital service?	<b>Yes or No</b>	If yes, please attach a copy of your DA card to this application.	
Did you have insurance coverage for this date of service?	<b>Yes or No</b>	If yes please provide appropriate billing information	

List your spouse and children (under the age of 18, natural or adoptive) who reside in or outside the home.

Name	Age	Reside in home			Relationship
		Yes	or	No	
		Yes	or	No	
		Yes	or	No	
		Yes	or	No	
		Yes	or	No	
		Yes	or	No	

Patient Employer \_\_\_\_\_ How long? \_\_\_\_\_ Hourly rate? \_\_\_\_\_ Hours per week? \_\_\_\_\_

Spouse Employer \_\_\_\_\_ How long? \_\_\_\_\_ Hourly rate? \_\_\_\_\_ Hours per week? \_\_\_\_\_

<b>GROSS INCOME (Before taxes)</b>	<b>PATIENT</b>	<b>CIRCLE ONE</b>	<b>SPOUSE</b>	<b>CIRCLE ONE</b>
3 months <b>OR</b> 12 months prior to date of service <b>TOTAL</b> income.		3 or 12 month		3 or 12 month
Current <b>MONTHLY</b> income				
List any other monthly income and <u>the source</u> of that income				
<b>EXPENSES</b>				
Rent/mortgage				
Medical bills/prescriptions				
<b>ASSETS</b>				
Own primary residence or other property				
Bank accounts/balances				
Other				

I understand that the above information is true and correct to the best of my knowledge and is subject to confirmation by Mount Carmel Health. I also understand that I may be asked for documented proof of income and/or assets to accompany this application. I also understand that if the information is determined to be false, I will be liable for payment of services. Please attach a letter explaining any extraordinary circumstances.

Signature \_\_\_\_\_

Date \_\_\_\_\_