FINANCIAL ASSISTANCE SCREENING APPLICATION

MOUNT CARMEL

Patient Name _____ Marital Status _____

Complete Address_____Phone_____

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 MCH hospital financial assistance

Were you a resident of Ohio at the time of service?	☐**Yes** ☐ **No**	Were you an active recipient of Disability Assistance on this date of service?	☐**Yes** ☐ **No**
Are you currently a resident in Ohio?	☐**Yes** ☐ **No**	Were you eligible for Medicaid, Medicaid with a Spend Down, Caresource, or Molina on this date of service?	☐**Yes** ☐ **No**
Are you residing in Ohio for the sole purpose of receiving health care?	☐**Yes** ☐ **No**	Did you have any other insurance coverage for this date of service?	☐**Yes** ☐ **No**
Is or will any other entity be held responsible/pursued for this debt? **If yes**, Name _____ Contact#_____	☐**Yes** ☐ **No**	**If you marked **yes** to any of the questions above, please send copies of your insurance cards or other proof of coverage so that we may bill them appropriately.	

List only your spouse and your natural or adopted children that are under the age of 18 who reside in/outside the home.

Name	Age	Reside in home	Relationship
		☐**Yes** ☐**No**	
		☐**Yes** ☐**No**	
		☐**Yes** ☐**No**	

If the patient is a minor, please provide both the mother and father's income in place of patient and spouse

GROSS INCOME (Before taxes)	PATIENT/MOTHER	SPOUSE/FATHER
3 months prior to date of service **TOTAL** income.	$	$
12 months prior to date of service **TOTAL** income.	$	$
What will your **TOTAL** expected income be by the end of this month?	$	$
List any other monthly income and **the source** of that income	$	$
If reported income is "$0" please provide a brief statement to explain how your normal living expenses are provided for.		

EXPENSES		
Rent/mortgage	$	$
Medical bills/prescriptions	$	$

ASSETS		
Own primary residence or other property?	☐**Yes** ☐**No**	Value: $
Bank accounts/balances?	☐**Yes** ☐**No**	Value: $

I attest that the above information is true and correct to the best of my knowledge and is subject to confirmation by Mount Carmel Health. I understand that I may be asked for documented proof of income and/or assets to accompany this application. For the purposes of the hospital assistance program, I authorize Mount Carmel Health to access my credit bureau report(s) to confirm this information. 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