



UNIVERSITY HOSPITALS FINANCIAL ASSISTANCE APPLICATION

If you believe you may qualify for financial assistance, complete this application. The entire application, including signature must be completed and signed to be considered. For questions or concerns related to this application, or for assistance completing, please call us at (419) 207-7878 or (800) 257-9917, Ext 3962 or visit us at any UH facility.

Patient Name: Patient Date of Birth: Date of Service:
Address: Marital Status: Account #:
City: Phone No: Facility Received: UH-Samaritan
State: Zip Code:

Were you an Ohio resident on this date of service?
Do you have health insurance covering these services?
Name of Insurance Company: Policy # Group #:
Are you eligible for COBRA?
Do you have Medicaid benefits?
Do you have an Health Reimbursement Arrangement Health Savings Account Flexible Spending Account

Please list all household members below. Include parents, spouses (regardless if they live in the home) & children (natural or adoptive) under the age of 18 living in the home along with the patient. Include copies of income verifications such as pay stubs, social security determinations, workers compensation, tax returns, or call a UH Financial Counselor to discuss other evidence that may be provided to demonstrate eligibility.

Table with 6 columns: Patient Family Members, Age, Relationship to Patient, Source of Income or Employer Name, Income for 3 months prior to date of service, Income for 12 months prior to date of service.

If you reported \$0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested above.

I also have bills from the following UH locations: CMC AHUJA RH RICHMOND RH BEDFORD GEAUGA GENEVA CONNEAUT PORTAGE ST JOHN ELYRIA PARMA SAMARITAN UH MEDICAL GROUP (UHMG)

By my signature below, I attest to the best of my knowledge and belief that the answers on this application are true. I understand that it is unlawful to knowingly submit false information to obtain government benefits. I further understand that other parties may rely on the information I provide herein. I hereby authorize them to do so.

Responsible Party Signature: X Date:
UH Representative Signature: X Date:

FOR OFFICE USE ONLY: #in HH 3mo TTL 12 mo TTL FPL HCAP UCAP AGB MI

Medical Record No: Date Completed:

MEDICALLY NECESSARY EXPENSES INCURRED IN CALENDAR YEAR 2017

This form is used to identify out of pocket medically necessary expenses to help determine if you qualify for additional account assistance under the UH Financial Assistance Policy.

ONLY COMPLETE IF YOU ARE AN INSURED PATIENT SEEKING ASSISTANCE OR IF YOU ARE UNINSURED AND YOUR INCOME IS GREATER THAN 250% OF THE FEDERAL POVERTY GUIDELINE

List all hospital, physician, & pharmacy services you have liability resulting from 2017 dates of service. Please note, insurance explanation of benefits must be provided for all expenses.

<u>SERVICE PROVIDER</u>	<u>SERVICE DATE</u>	<u>DUE FROM PATIENT</u>	<u>OFFICE USE ONLY</u>
_____	_____	_____	<input type="checkbox"/> NMN excluded <input type="checkbox"/> Recvd
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TOTAL PATIENT OWES THIS CALENDAR YEAR _____

Questions on how to complete this application? Call us at (419) 207-7878 or (800) 257-9917, extension 3962

Please submit your completed application to UH-Samaritan Medical Center, Patient Financial Services, 1025 Center Street, Ashland, OH 44805

FOR OFFICE USE ONLY: FPL _____ 10 15 20 25 NOT QUALIFIED **Date Completed:** _____