University Hospitals

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? o Yes o No

Do you have health insurance covering these services? o Yes o No *If yes, enter information below & attach copy of insurance card*

Name of Insurance Company:_____ Policy # _____ Group #: _____

Are you eligible for COBRA? o Yes o No

Do you have Medicaid benefits? o Yes o No *If yes, enter billing #_____& attach copy of Medicaid card*

Do you have an o Health Reimbursement Arrangement o Health Savings Account o 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.

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
Patient -		self			
2.					
3.					
4.					
5.					

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 _____ o HCAP o UCAP o AGB o MI

Medical Record No: _____ **Date Completed:** _____

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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.

SERVICE PROVIDER	SERVICE DATE	DUE FROM PATIENT	OFFICE USE ONLY
			❑ NMN excluded ❑ Recvd
			❑ NMN excluded ❑ 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** _____ **o 10 o 15 o 20 o 25 o NOT QUALIFIED** **Date Completed:** _____