APPLICATION FOR FINANCIAL ASSISTANCE

University of Cincinnati Medical Center ☐ West Chester Hospital ☐ Daniel Drake Center ☐ University of Cincinnati Physicians ☐

PLEASE PRINT:

Today's Date: ____ / ____ / ____ (Month / Day / Year) Med Rec # ________ Account # ________

Patient Name: ________ Last ________ First ________ M.I.

Responsible Party, if not Patient: ________ Last ________ First ________ M.I.

Patient Address: ________ Street ________ Apt. #

________ City ________ County ________ State ________ Zip

Home Phone: ___ - ___ - ____ (Area Code) **Work Phone:** ___ - ___ - ____ (Area Code)

Email Address: ________

Patient Social Security Number: ___ - __ - ____

Patient Date of Birth: __ / __ / __ (Month / Day / Year) **Date of Service:** __ / __ / __ (Month / Day / Year)

Please list all family members (including you). Family members include the applicant, their spouse* and children (natural or adoptive) under the age of 18 living in the home along with the applicant. Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security benefits, public assistance, etc.

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
1.					
2.					
3.					
4.					
5.					
6.					

*The State of Ohio does not have a legal distinction of "legally separated" for married couples. Until a final decree of divorce, annulment, dissolution, etc. is granted a separated couple is the same as a married couple and the spouse must be included as a family member.

UC HEALTH
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	Yes		No	
Were you an Ohio resident at the time of your hospital service?	**Yes**		**No**	
Were you a United States citizen at the time of your hospital service?	**Yes**		**No**	
Did you have health insurance at the time of your hospital service?	**Yes***		**No**	
Were you an active recipient of Disability Assistance or Medicaid at the time of your hospital service?	**Yes***		**No**	

** If you answered "Yes" to either of the above two insurance questions, please attach a copy of your insurance card (front and back), Medicaid or Disability Assistance card to this application and complete the following:*

Name of Insurance Company:

Policy Number: **Group Number:**

Insurance Phone Number: **Medicaid or Disability Assistance Number:**

If you reported $0.00 income above, please have the Support Statement below completed by the person(s) helping to support you and/or your family.

SUPPORT STATEMENT

For applicants who stated zero income, the person(s) providing you with basic financial support must provide a brief explanation as to how you are being financially supported. List services, if any, that you are receiving from patient for providing this support.

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I hereby certify and verify that all of the foregoing information given is true and correct to the best of my knowledge and belief. I understand that my signature does not obligate me to be financially responsible for charges rendered to the person for whom I am providing basic financial support.

Signature of person providing financial support to applicant **Address**

City, State Zip

By my signature below, I certify that I have carefully read this application and that everything I have stated or provided in any attachment is true and correct to the best of my knowledge and belief. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Patient/Guarantor Signature: ____________________ **Date Completed:** _______________

If you have questions or need assistance with this application, please call 513-585-6200 or 1-800-277-0781 or visit our website: http://uchealth.com/financial/financial-assistance/.