UC Health

Dear Patient:

We provide full or partial financial assistance to persons whose family income is at or under the income guidelines listed below.

Eligibility depends upon:

- Cooperation with applying for Medicaid
- Being deemed ineligible for Medicaid
- Meeting income qualifications as outlined below
- Meeting residency requirements

To determine if you may be eligible for available financial assistance programs, you must provide a completed Financial Assistance Application, along with a copy of one of the documents from each category listed on page 2 of this letter. Upon receipt, we will process your application and notify you of our determination.

INCOME GUIDELINES

Family Size	Income Per Year
1	$29,160
2	$39,440
3	$49,720
4	$60,000
5	$70,280
6	$80,560

* For families greater than 6, add an additional $10,280 for each member.

Financial assistance is not health insurance and does not meet the criteria for health insurance as defined by the Affordable Care Act. Financial assistance approvals are valid only for balances not covered by a third party. Financial assistance does not cover balances resulting from your failure to follow through with requests for information from your insurance company or failure to cooperate with the Medicaid application process. Financial assistance may not be used for non-covered services for Medicaid recipients.

UC Health's Financial Assistance is for certain hospital charges and physician charges incurred at a UC Health hospital or UC Health physician's office. Cosmetic charges, durable medical equipment, home health care, transportation or third-party skilled nursing services are not covered.

If you have any questions, please call (513) 585-6200 or (800) 277-0781. If you believe you are not eligible for financial assistance under the above programs, Customer Service can discuss other program qualifications or payment arrangements with you at that time.

Thank you for choosing UC Health for your medical care.

Please complete and sign the Financial Assistance Application and provide a copy of 1 of the following documents from each category:

Category 1 – Proof of Income:

- If you are claiming that you have no income, a sworn statement from the person providing you with basic financial support, validating your lack of income must be completed.
- Check stubs for three months prior to the date of service (including payroll, Social Security, Worker's Compensation, unemployment compensation, etc.) or comparable payment record. If you are self-employed, please send a notarized statement of income and expenses for the three-month period prior to the date of service.
- A letter from your employer setting forth compensation details on official employer letterhead with contact information.
- Court support order.
- Copy of benefit letter / check (ex. Social Security Benefit Letter).
- Letter from tenant setting forth rental income.

Note: We do NOT accept tax returns, bank statements, Forms 1099, Forms W-2, etc. as proof of income.

Category 2 – Proof of Residency:

- Driver's license or vehicle registration - matching your current address.
- Rent receipts for rent paid within 60 days of when the services are rendered.
- Mortgage statement.
- Utility bill, credit card bill or bank statement postmarked or dated by the issuer within 60 days of when the services are rendered.
- Confirmation of address if a home visit is made by hospital staff.
- Copy of most recent Hamilton County property tax bill.
- Address confirmation by collection agency.
- Letter from lease management, mortgage company, or person providing the patient with shelter, including homeless shelters.

Where to send your completed application:

Mail to:	Fax to:
UC Health Correspondence Unit 3200 Burnet Avenue Cincinnati, OH 45229	513-585-6102 E-mail to: pfs@uchealth.com

UC Health

APPLICATION FOR FINANCIAL ASSISTANCE

University of Cincinnati Medical Center | **West Chester Hospital** | **Daniel Drake Center for Post Acute Care** | **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.		Self			
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
APPLICATION FOR FINANCIAL ASSISTANCE

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:			
Insurance Phone Number:		**Medicaid or Disability Assistance Number:**	
Policy Number:		**Group 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.

_____

_____

_____

_____

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.