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 1-800-931-6642 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: ____________________

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

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 M**

Medical Record No: ______________ **Date Completed:** ______________

University Hospitals

MEDICALLY NECESSARY EXPENSES INCURRED IN THE PREVIOUS CALENDAR YEAR

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 the previous calendar year. Please note, insurance explanation of benefits must be provided for all expenses.

SERVICE PROVIDER	SERVICE DATE	DUE FROM PATIENT	OFFICE USE ONLY
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TOTAL PATIENT OWES THIS CALENDAR YEAR ____________________

Questions on how to complete this application? Call us at 1-800-931-6642

Please submit your completed application to University Hospitals CSC 2800, Attention : Kim Pope, 20800 Harvard Road Highland Hills, Ohio 44122, CSC lower level Cube #L1222C

FOR OFFICE USE ONLY: **FPL__________** **o 10** **o 15** **o 20** **o 25** **o NOT QUALIFIED** **Date Completed:________________________**