

## 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 (216) 844-8299 or (800) 859-5906 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?       Yes       No

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

Name of Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_ Group #: \_\_\_\_\_

Are you eligible for COBRA?       Yes       No

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

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.

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
<b>Patient -</b>		self			
<b>2.</b>					
<b>3.</b>					
<b>4.</b>					
<b>5.</b>					

*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 \_\_\_\_\_  HCAP     UCAP     AGB     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.

<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
_____	_____	_____	<input type="checkbox"/> NMN excluded <input type="checkbox"/> Recvd
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_____	_____	_____	<input type="checkbox"/> NMN excluded <input type="checkbox"/> Recvd

**TOTAL PATIENT OWES THIS CALENDAR YEAR** \_\_\_\_\_

Questions on how to complete this application? Call us at (216) 844-8299 or (800) 859-5906

Please submit your completed application to University Hospitals, Customer Service Center, 20800 Harvard Ave, Beachwood, OH 44122

**FOR OFFICE USE ONLY:** FPL \_\_\_\_\_ o 10 o 15 o 20 o 25 o NOT QUALIFIED Date Completed: \_\_\_\_\_