APPLICATION FOR FINANCIAL ASSISTANCE

PLEASE PRINT

Today's Date:_____
MONTH DAY YEAR

Responsible Party:_____
LAST FIRST M.I.

Patient Name:_____
LAST FIRST M.I.

Patient Address (at time of hospital service):_____
STREET APT. NO.

_____ _____ _____ _____
CITY COUNTY STATE ZIP CODE

Date of Hospital Services: _____ Patient Birth Date: _____
MONTH DAY YEAR MONTH DAY YEAR

Did the patient have health insurance or Medicaid at the time of the hospital service? Yes* ☐ No ☐

*If you answered "Yes", please attach a copy of the insurance card (front and back) or Medicaid card that covers the patient and complete the following:

Name of Insurance Company:_____

Policy Number:_____ Group Number:_____

Insurance Phone Number:_____ Medicaid Number:_____

Please complete the following:

List family members, including parents, patient, siblings (natural or adopted under age 18 living at home).

FAMILY MEMBERS	AGE	RELATIONSHIP TO PATIENT
1.		
2.		
3.		
4.		

List **ALL** income for responsible party including gross (pretax) wages, rental income, unemployment, social security benefits, child support, etc.

FAMILY MEMBER	SOURCE OF INCOME OR EMPLOYER NAME	INCOME 3 TO 12 MONTHS **BEFORE** THE DATE OF SERVICE

Your signature is required on the back of this application.

In addition to the completed financial assistance application, we also need the following documentation:

1. **Proof of all gross (pretax) income** for the responsible party, including at least two (2) paycheck stubs or a letter from your employer indicating your income for the last 3 or 12 months; child support, alimony, or social security income statements; and/or your unemployment compensation letter.

2. **Proof of Residency** including a copy at least one of the following (dated at within the last 60 days): a utility bill (gas or electric), phone or cable bill, a rent receipt, a credit card bill, your voter registration card or a copy of your driver's license or state identification card.

By my signature below, I certify that I have carefully read this application and that everything I have stated or any documentation I have attached 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.**

Responsible Party Signature_____ Date Completed_____

If you reported $0.00 income on the front of this application please have the Support Statement below completed by the person(s) providing help to you and/or your family.

SUPPORT STATEMENT

(To be completed by the person providing support to the patient)

I have been identified by the parent and/or patient as providing financial support. Below is a list of services and support that I provide.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby certify and verify that all of the information given above is true and correct to the best of my knowledge and belief. I understand that my signature **will not** make me financially responsible for the patient's medical charges.

Please attach Proof of Residency, such as a copy of a utility or cable bill with your address on it, dated within the last 60 days of the hospital service date provided on the front page of this application.

Signature_____

Address_____

If you have any questions, please contact the Financial Counseling Department of Cincinnati Children's Hospital Medical Center at 513-636-0201 or 1-800-344-2462, ext. 60201.

Our hours are 8 a.m. to 4:30 p.m. Monday – Friday. Our fax number is 513-636-5489.