Cincinnati Children's Hospital Medical Center

Please return to:
Cincinnati Children's Hospital
Financial Counseling Department
MLC 5011, 3333 Burnet Avenue
Cincinnati, Ohio 45229-3026

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 medical care**:_____
STREET APT. NO.

_____ _____ _____ _____
CITY COUNTY STATE ZIP CODE

Current Address_____
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 ID Number: _____

Please note discounts do not apply to professional services rendered by Dr. Robin Cotton and does not cover copayments. **Also note that *discounts may not apply if a Health Savings Account (HSA), Health Reimbursement Account (HRA) or similar fund designated for family medical expenses* has been established**. Payment from either fund is due before any discount can apply.

Please complete the following:
List family members, including parents, patient, siblings **(natural or adopted under age 18 living at home).** List any additional family members in the Support Statement box on the next page.

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

List **ALL** income for family members including gross (pretax) wages, rental income, unemployment, social security benefits, child support, etc. Family members include parents, the patient and siblings (natural or adopted under age 18 living at home. List any additional income in the Support Statement box on the next page.

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: a) including 4 paycheck stubs from two months before the date of medical care or a letter from your employer indicating your income at the time of medical care, b) child support, alimony, or social security income statements, and/or c) your unemployment compensation letter.

2. **Proof of Residency** including a copy at least **one** of the following dated around the date that medical care was received. Acceptable documents can be 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.

_____

_____

_____

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_____

_____

_____

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** from the period of time the medical care was received provided.

Signature_____

Address_____

If you have any questions, please contact the Financial Counseling Department of Cincinnati Children's Hospital Medical Center, MLC 5011, 3333 Burnet Avenue, Cincinnati, Ohio 45229-3026 or by calling 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 513-636-2225