

Financial Assistance Application Form

Please fill out all information completely, If it does not apply, write "N/A". Attach additional documents if needed.

SCREENING INFORMATION			
Do you have health insurance covering the services?	Yes ☐	No ☐	
If no, why not?			
Do you have Medicaid or Medicaid Spend Down?	Yes ☐	No ☐	if yes, how much is the Spend Down?
If yes, how much is the Spend Down?	\$		
Do you have a Health Savings Account or Flex Plan?	Yes ☐	No ☐	
If yes, what is the balance?	\$		
Do you have Disability Assistance (DA) benefits?	Yes ☐	No ☐	
Is this service a result of an accident?	Yes ☐	No ☐	
Is this service work related?	Yes ☐	No ☐	
Are you holding anyone liable for this bill?	Yes ☐	No ☐	
Are you a Citizen of the United States?	Yes ☐	No ☐	

PLEASE NOTE
- We cannot guarantee that you will qualify for financial assistance, even if you apply. - Once you send in your application, we may check all the information and may ask for additional information or proof of income. - Within 14 calendar after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION			
Patient Name:			
Relationship to Patient		Patient's DOB:	
Address:		Patient's SSN:	
City:		Marital Status:	
State/Zip:		Employment Status:	
Phone Number:		Email Address:	

FAMILY INFORMATION					
Family Members living in the home at time of service, include the patient (applicant)	Age	Relationship to Patient at time of Service	Source of Income Or Employers Name at time of service	Current Income at Time of Service Previous 3 months x 4	12 months preceding date of service
1.					
2.					
3.					
4.					
5.					
6.					
TOTALS					

****If you report \$0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested above. ****

I affirm that the answers on this application are true, and I understand that it is unlawful to knowingly submit false information to obtain government benefits.

Responsible Party Signature: _____ Date Completed: _____

By my signature below, I affirm to the best of my knowledge and belief that the answers on this application are true. I further understand and agree that other parties may rely on the information I provide herein. I hereby authorize them to do so.

Hospital Representative Signature: _____ Date Completed: _____

Return your completed application to: **Glenbeigh Attn: PFS; PO Box 298; Rock Creek, OH 44084-0298**