HOSPITAL CARE ASSURANCE APPLICATION/ UNINSURED FINANCIAL ASSISTANCE APPLICATION

Lake Health

Patient Name: _____ Medical Record Number: _____ Account Number: _____

Address: _____ Month of Service: _____ Family Member Interviewed: _____

City: _____ Patient's Date of Birth: _____ Responsible Party: _____

State: _____ Zip Code: _____ Patient's Phone #: _____ Relation to Patient: _____

Are you a resident of the State of Ohio? ❑ Yes ❑ No

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

Name of insurance company_____ Policy # _____ Group # _____

Do you have Medicaid benefits? ❑ Yes ❑ No If yes, enter billing # _____ and attach copy of Medicaid card

Do you have Disability Assistance (DA) benefits? ❑ Yes ❑ No If yes, enter billing # _____ and attach copy of DA card

Please list all family members (including yourself). Additional family members can be listed on an attached piece of paper. Family members include parents, spouses & children (natural or adoptive) under the age of eighteen (18) living in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, social security benefits, public assistance, etc.

Family Members	Age	Relationship to Patient	Source of Income (Name Employer)	Income for 3 Months Prior to Date of Service	Income for 12 Months Prior to Date of Service
1.					
2.					
3.					
4.					
5.					
6.					
TOTALS					

HOUSEHOLD INCOME VERIFICATION DOCUMENTATION: Include all documents verifying your household income for the three (3) months or the twelve (12) months prior to the date(s) of service. This may include your W-2s, Social Security award letter, pay stubs or letters from employers. For self-employed ONLY: Income Tax Forms and schedules are acceptable. If you have not filed your tax return, you can call 1-800-829-1040 to obtain a Proof of Non-Filing letter from the IRS. **If family members had no income during the above time periods, please mark "NONE" as the income source and place $0.00 as the income. If you reported $0.00 or no income above, please provide a brief explanation of how you (or the patient) survived financially during the above time period:**

_____

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

Applicant Signature: _____ Date Completed: _____

Additional family members may be added on the back of this sheet. This application is valid for thirty (30) days only. A new or updated application is required for each month in which services are provided. Please return all financial assistance applications to Patient Financial Services at HCAP@lakehealth.org or 7590 Auburn Rd., Concord, OH 44077, or any Lake Health location.