Information Needed for Financial Assistance Application

- ❑ Copies of pay stubs for the last (3) months which includes the year-to-date amount and/or front page of tax returns for the most recent year.
- ❑ If Self Employed, copy of tax form with Schedule C
- ❑ Bank accounts, copies of most recent statement
- ❑ Copy of Medicaid denial letter
- ❑ Child support, only if patient is a child
- ❑ Social Security,1099 award letter
- ❑ Unemployment or Worker's Comp, award letter
- ❑ Veterans/Disability, award letter
- ❑ Complete, signed application
- ❑

If additional information is needed, East Ohio Regional Hospital will contact you regarding the additional information being requested.

Proof of income will not be returned, please do not send originals.

Please mail completed application along with copies of income verification to:

East Ohio Hospital
c/o Denise Archbold
90 North 4th Street
Martins Ferry, OH 43935
Fax: (740) 633-4483

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If you have questions on completing this application, please contact Denise Archbold, Financial Counselor at 740-633-4778.

PATIENT NAME: _____ DATE OF APPLICATION: ___/_____/____

APPLICANT NAME, IF NOT PATIENT: _____
(If the applicant is not the patient, please answer the following questions as they apply to the patient.)

STREET: _____

CITY: _____ STATE:_____ ZIP CODE:_____

DATE(S) OF HOSPITAL SERVICE: From _____ To_____

1. Were you an Ohio resident at the time of your hospital service? Yes____ No____

2. Were you an active Medicaid recipient at the time of your hospital service? Yes____ No____

If yes, Medicaid recipient ID number: _____

3. Did you have health insurance (other than Medicaid) at the time of your hospital service?
Yes____ No____

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of HCAP, Family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home.

If the patient is under the age of eighteen, the Family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s)' children under 18 (natural or adoptive) who live in the patient's home.

Name	Age	Relationship to Patient	Income prior 3 months*

Income for 12 months prior to hospital service* Type of income verification attached* (Patient) self Total persons in family Total family income *Income verification, if required by the hospital, may include pay stubs, w-2s, or other documents containing income information for the appropriate time period (3 or 12 months prior to hospital service).

By my signature below, I certify that everything I have stated on this application and on any attachments is true.

_____ _____
Applicant Signature Date