DATE OF SERVICE: _____ **ACCOUNT NUMBER:** _____

Please Print All Information

PATIENT OR APPLICANT NAME (LAST, FIRST, M)	SOCIAL SECURITY NO.	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP CODE	DAYTIME PHONE

MARITAL STATUS:
☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED

WERE YOU AN OHIO RESIDENT AT THE TIME OF YOUR HOSPITAL SERVICE?
☐ YES ☐ NO ; IF "NO", WHAT STATE DID YOU RESIDE IN? _____

THE FOLLOWING QUESTIONS MUST BE COMPLETED FOR FINANCIAL ASSISTANCE CONSIDERATION

1. **HAVE YOU APPLIED FOR MEDICAID OR OTHER COUNTY ASSISTANCE?** YES _____ NO _____
   a. IF "YES", WHAT DATE DID YOU TURN IN APPLICATION? _____
2. **DID YOU HAVE HEALTH INSURANCE COVERAGE(S) ON THE DATE OF SERVICE?** YES _____ NO _____
   a. IF "YES", NAME OF INSURANCE: _____ ID# : _____
   b. IF "YES", (AND THE INSURANCE HAS NOT BEEN BILLED) PLEASE SEND A COPY OF YOUR INSURANCE CARD(S) WITH THIS APPLICATION.
3. **HAVE YOU APPLIED FOR INSURANCE THROUGH THE HEALTH INSURANCE EXCHANGE?** YES _____ NO _____
   a. IF "YES", WHAT IS THE NAME OF THE INSURANCE _____
4. **WAS THE DATE OF SERVICES RELATED TO AN AUTO ACCIDENT?** YES _____ NO _____
   a. IF "YES", DID YOU FILED A CLAIM? YES _____ NO _____
      i. CLAIM NUMBER: _____ INSURANCE NAME: _____
5. **DO YOU HAVE A HEALTH SAVINGS ACCOUNT (HSA) AND/OR MEDICAL SAVINGS ACCOUNT?** YES _____ NO _____
   a. IF "YES", PLEASE SEND COPY OG DOCUMENTATION SHOWING YOUR CURRENT BALANCE.
6. **PLEASE INDICATE IF ANYONE IN YOUR HOME HAS THE FOLLOWING RESOURCES**.
   a. DO YOU OWN OR RENT YOUR HOME? OWN _____ RENT _____
   b. CHECKING/SAVINGS: YES _____ NO _____ IF "YES", LIST TOTAL VALUE $_____
   c. OTHER ASSETS INCLUDING BUT NOT LIMITED TO CD'S/STOCK/BONDS/MONEY MARKET ACCOUNTS: YES _____ NO _____
      i. IF "YES", LIST TOTAL VALUE $_____

LIST EACH MEMBER OF YOUR HOUSEHOLD INCLUDING YOURSELF AND EACH MEMBER'S INCOME INCLUDING YOURSELF.

(IF YOU NEED ADDITIONAL SPACE, PLEASE USE THE BACK OF THIS FORM).

Income is considered to be total income BEFORE taxes are taken out, and includes but is not limited to: EMPLOYEMENT WAGES or SALARIES, UNEMPLOYMENT, WORKERS COMP, PENSION OR RETIREMENT, 401K, SOCIAL SECURITY, RENTAL INCOME, SELF EMPLOYEMNT, CHILD SUPPORT, ALIMONY, VA BENEFITS, ANNUITIES, CASH RECEIPTS, ANY OTHER INCOME.

SEND PROOF OF 3 MONTH OR 12 MONTH INCOME WITH THIS APPLICATION (REQUIRED):

FAMILY MEMBER'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	TOTAL INCOME IN THE 3 MONTHS PRIOR TO DATE OF SERVICE	TOTAL INCOME IN THE 12 MONTHS PRIOR TO DATE OF SERVICE	SOURCE OF INCOME OR EMPLOYER NAME (STATE IF COLLEGE STUDENT)
(PATIENT)	SELF				
(SPOUSE)					
				If zero must complete $0 INCOME STATEMENT below	
TOTAL PERSONS IN FAMILY:			TOTAL FAMILY INCOME:		

$0 INCOME SATEMENT:

Provide brief statement of how basic food/housing needs were met within the three months before date of service

**Income of a spouse or parent who does not live in the home is required unless the absent spouse or parent does not contribute to the house hold; use INCOME block to document "Does not contribute".

**Income verification includes, but is not limited to copies of total wages before taxes, pension, SSI/SSD/Unemployment benefits, alimony, child support (if child is patient), veterans' benefits, distributions from a retirement account (IRA), 401/k, and 401(b).

***If you receive Social Security or Disability Benefits, a letter of income verification or your most recent 1099 form may be submitted. A letter of verification can be obtained by calling the Social Security Administration at 1-800-772-1213.

I, the undersigned, have provided the above information to be considered for financial assistance through Mercy Health and;
To the best of my knowledge, I state this to be true and accurate information, and;
I understand that these are Federal Funds and accept the responsibility of their use on my behalf, and;
I understand that Mercy Health reserves the right to modify or cancel this program in accordance with the rules of the Ohio Department of Jobs and Family Services.

_____ _____
(PATIENT OR A LEGAL REPRESENTATIVE OF A PATIENT MUST SIGN FOR APPLICATION TO BE VALID) (DATE)

_____ _____
(HOSPITAL REPRESENTATIVE SIGNATURE/ DEPT. OR AGENCY) (DATE)

Mercy Health
ATTN: Financial Assistance
16001 Bay Vista Drive
Clearwater, FL 33760