How to Complete the Financial Aid Form

Field Description	***Details***
Patient Name	Patient Name (please print)
Date of Birth	Patient's Date of Birth
Address	Patient's Current Address (please print)
Medical Record Number	For Office Use Only
Was the Patient a Resident of Ohio?	Answer yes or no. Residency is established by a person who is living in Ohio voluntarily at the time of the hospital service, is not receiving public assistance in another state and did not come to Ohio for the sole reason of having healthcare services
Did the patient have Medical Insurance at the time of service?	Answer yes or no. If yes, please attach a copy of your insurance card
Was the patient an active Medicaid recipient at the time of service?	Answer yes or no. If yes, please attach a copy of your Medicaid card.
Date of Hospital Service	Date (or admission date) the patient was seen at the hospital
Family Members	List by name, the family members in the immediate family INCLUDING yourself (patient), patient's spouse (living in the home or not), patient's children under 18 (natural or adoptive) who live in the same home as the patient. If the patient is a minor, both biological parents must be listed on the application (living in the home or not).
Date of Birth	Date of birth of each of the persons in the household.
Relationship to Patient	List how this person is related to the patient. Example: Patient (self), Spouse, Child (natural or adoptive) or Parent (if the patient is a minor)
Total Income received within the three (3) months PRIOR to date of service	Enter amount of GROSS income each person received within the 90 days before the service date. If there was no income received within 90 days prior, enter 0. *Example: Date of service 4/1/12 – how much income was received 1/1/12 thru 3/31/12*
Total Income received within the twelve (12) months PRIOR to date of service	Enter amount of GROSS income each person received within the 12 months before the service date. If there was no income received within 12 months prior, enter 0. *Example: Date of service 4/1/12 – how much income was received 4/1/11 thru 3/31/12*
Source of Income	List the employer's name or any other source of income for this person. This would include unemployment, Social Security, VA, pensions, etc.
Start / Hire Date	List the start or hire date at this job, or the date the benefits began, such as with unemployment, Social Security, retirement, etc.
If you report a $0 income, please provide a brief explanation of how you survived financially.	Explain your means of support for the 3 and 12 months prior to the service date. If you received support from another person, please have that person provide a letter stating the time period they have supported you and the type of support they have provided (ex. food, shelter, etc.). Please also have that person sign and date the letter.
Applicant's signature	The application must be signed by the patient, their spouse, parent (if the patient is a minor) or legal representative (attach copy of Power of Attorney).
Date	The application must be dated the date it is completed.
Relationship to Patient	State the relationship of the person signing the application (if not the patient).
Phone Number	The patient's phone number (including area code)

Please attach copies of income verification for the 3 and 12 months PRIOR to the service date. (Do not send originals as they cannot be returned)

Note: Make sure your account number is written at the top of all papers sent with the application

The application cannot be signed and dated more than 7 days prior to the service date.