THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

FOR ASSISTANCE PAYING YOUR ACCOUNT

If you wish to be considered for financial assistance programs, complete the entire form below and return it to the OSU Wexner Medical Center.

You are not eligible for Financial Assistance if you are entering the State of Ohio solely to seek medical treatment.

If you need further assistance in paying your OSU Wexner Medical Center bill, call 614-293-2100.

Patient's Name_____ Today's Date: _____
Address: _____
Date of Birth _____Medical Record Number (for office use only): _____

1) Was the patient a resident of Ohio at the time of service? ..... Yes_____ No_____
2) Did the patient have Medical Insurance at the time of service? ..... Yes_____ No_____
3) Was the patient an active Medicaid recipient at the time of service? ..... Yes_____ No_____

If you answered **yes** to question 2 or 3 please attach a copy of your insurance or Medicaid card to this application.

Date of Hospital service: _____

Please provide the following information for all of the people in your immediate family.
For purposes of HCAP, "family" is defined as the patient, the patient's spouse (living in the home or not) and all of the patient's children under age 18 (biologic or adoptive) who live in the patient's home. (add additional pages as necessary)
** If the patient is a minor, both biological parents must be listed - even if they do not live in the home.

Name	Date of Birth	Relationship to Patient	Total Income received within the three (3) months PRIOR to date of service	Total Income received within the twelve (12) months PRIOR to the date of service	Source of Income (Job, Pension, Social Security, Unemployment, etc.)	Start / Hire Date
		patient	**$**	**$**		
			$	**$**		
			$	**$**		
			$	**$**		
			$	**$**		

Please check type of income verification attached: Income verification must include the 3 and 12 months PRIOR to the service date. (please send copies – originals will not be returned)

- ❑ Copies of Pay Stubs
- ❑ Social Security / Pension / Disability benefit letter
- ❑ Letter from employer stating gross income received
- ❑ Unemployment benefit verification
- ❑ Verification of **any** income received

If you report a **$0 income**, please attach a brief explanation of how you survived financially for the 3 and 12 months prior to the date of service. If you receive support from someone, please have that person provide a letter stating the time period they have supported you and the type of support they have provided.

If your household income is over the Federal Poverty Level, we will review your account for additional assistance programs. This review may include obtaining information from your credit report.

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

_____ _____
Applicant's signature Date

_____ (____)_____
Relationship to Patient (if not patient) Patient's Phone Number

Comments (office use only): _____

_____

Return this form with income verification to:
OSU Wexner Medical Center
Financial Assistance Department
PO Box 183107
Columbus, OH 43218-3107
Fax #: 614-293-2260
E-mail: financialassistance@osumc.edu

Office Use Only
Reviewed by: _____ Scan to FIN-ASST