KETTERING HEALTH NETWORK

Kettering Memorial Sycamore Grandview Southview Greene Memorial Fort Hamilton
Soin Beavercreek Medical Center Kettering Behavioral Medicine Center

PATIENT APPLICATION FOR FINANCIAL ASSISTANCE

Telephone Number _____ **Social Security Number**_____-_____-_____

Patient Name _____ **Date of Birth**_____/_____/_____

Name of person completing application_____

Street address_____

City _____ **State** _____ **Zip Code**_____

Date(s) of Hospital Service _____

Were you an Ohio resident at the time of your hospital service? **Yes** _____ **No** _____

Were you an active Medicaid recipient at the time of your hospital service? **Yes** _____ **No** _____

Have you applied for Medicaid benefits within the last 90 days? **Yes** ____ **No** _____

Were you an active recipient of Disability Assistance at the time of your hospital service? **Yes** _____ **No** _____

REQUIRED: Total number of eligible family members (including patient) that live in the household: _____

Eligible family members include spouse, natural and legally adopted children under the age of 18. If the patient is under 18 years old the eligible family members will include birth parents, legally adopted parents, and true siblings.

Please list eligible family member names and ages, and check the appropriate relationship box below

Family Member Name	Age	Parent	Spouse	Brother	Sister	Child

Please attach a list of additional dependents
Reported income must be for time periods prior to date(s) of hospital service

REQUIRED

2. **Total gross family income for the previous 3 months** $ _____
3. **Total gross family income for the previous 12 months** $_____
4. **If reported $0 income, provide a brief explanation of how you are meeting your monthly obligations.**

_____

By my signature below, I certify that everything I have stated on this application is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to the verification by KETTERING HEALTH NETWORK. I understand that if any information I have given proves to be untrue KETTERING HEALTH NETWORK will reevaluate my financial status and take appropriate action.

Signature of Applicant_____ **Today's date** _____

This application is valid for 45 days after the original date of service for inpatient stays, and 90 days for outpatient.