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

Patient Name _____ Date of Birth _____

Telephone Number _____ Social Security Number _____

Name of person completing application_____
(If someone other than the patient, please list the reason the patient is unable to sign for themselves)

_____

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 _____

Marital Status: Married ___ Divorced ___ Widow(er) ___ Single ___ Domestic Partner __

REQUIRED: Household size (including yourself, your spouse or domestic partner, all dependents, and other members of the household): *

Spouse/ domestic partner information:
Name: _____
Date of Birth: _____

List all household members who need to be considered for financial assistance (see next page to list additional household members if necessary)
Be sure to include all household members and their relationship to the patient as HCAP and KHN Charity calculate family size in different ways. (only married, natural born, or adopted relatives will qualify for an HCAP household)

Dependent's Name: _____
Date of Birth: _____**Relationship:** _____

Dependent's Name: _____
Date of Birth: _____**Relationship:** _____

Dependent's Name: _____
Date of Birth: _____**Relationship:** _____

Dependent's Name: _____
Date of Birth: _____ **Relationship:** _____

Dependent's Name: _____
Date of Birth: _____ **Relationship:** _____

REQUIRED: Monthly Gross Income (all income from household must be reported)
Reported income must be for time periods prior to date(s) of hospital service

Wage Earner	Patient	Spouse/Other
Cash income (not including gifts)		
Gross Social Security income		
Social Security Disability (SSDI)		
Supplemental Security Income (SSI)		
Pension/Retirement		
VA Benefits		
Temporary Disability Income (TDI)		
Unemployment Benefits		
Alimony		
Child Support		
Housing or rental assistance		
Rental property income		
Other: (describe)		
Total Monthly Income:		

If household income is zero please initial here _____ and give a brief explanation of your financial situation.

_____

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. I understand that I may have to provide Proof of Income as defined by KHN, and not submitting requested documentation will result in the denial of my application.

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

Do Not Write Below This Line: For Financial Counselor Use Only_____

Total household monthly income: _____ HCAP only applicable monthly income: _____

Total household family size: _____ HCAP only applicable family size: _____

Patient is qualified for:

HCAP Extended Charity* Basic Charity Over Income for All Programs

*** PROOF OF INCOME WILL BE REQUIRED FOR ALL EXTENDED CHARITY APPLICATIONS**