KETTERING HEALTH NETWORK

PATIENT APPLICATION FOR FINANCIAL ASSISTANCE

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

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: _____

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

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 _____

Were you an active recipient of Disability Assistance at the time of your hospital 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)

(Parent) Name: _____Date of Birth: _____(age)_____Relationship: _____

Name: _____Date of Birth: _____(age) _____Relationship: _____

Name: _____Date of Birth: _____(age)_____Relationship: _____

Name: _____Date of Birth: _____(age)_____Relationship: _____

Name: _____Date of Birth: _____(age)_____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

Household Income	Patient	Spouse or Domestic Partner	Dependent 18- 20 years	Parent or Care Taker
Employment Income				
Gross Social Security Income				
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	$	$	$	$

REQUIRED:

1. **Has there been any changes in your monthly income within the previous 12 months? Yes_____ No_____**
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. 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 _____

Please complete application and forward with income proof to KHN Financial Assistance 2110 Leiter Rd. Miamisburg, OH 45342