

# KETTERING HEALTH NETWORK

## PATIENT APPLICATION FOR FINANCIAL/MEDICATION ASSISTANCE

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

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Telephone Number \_\_\_\_\_ 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)**

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				
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.

\_\_\_\_\_

I authorize KHN to submit, exchange personal information documentation to pharmaceutical manufacturing companies for purpose of helping me obtain financial assistance for my medication expenses and certify by my signature below, 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 assistance eligibility 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 \_\_\_\_\_  
*If signed by someone other than the patient, list full name and the reason the patient is unable to sign for themselves*

\_\_\_\_\_

**Please complete application and forward with income proof to KHN Financial Assistance 2110 Leiter Rd. Miamisburg, OH 45342 or email to [FinancialCounselors@ketteringhealth.org](mailto:FinancialCounselors@ketteringhealth.org)**