FINANCIAL ASSISTANCE APPLICATION

PATIENT OR APPLICANT NAME:_____

ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

PHONE:_____MARITAL STATUS:_____

DATE OF SERVICE: _____

RUN #:_____

THE FOLLOWING MUST BE COMPLETED FOR FINANCIAL ASSISTANCE CONSIDERATION.

NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	TOTAL GROSS INCOME IN THE 3 MONTHS PRIOR TO THE DATE OF SERVICE	TOTAL GROSS INCOME IN THE 12 MONTHS PRIOR TO THE DATE OF SERVICE	SOURCE OF INCOME EMPLOYER NAME (STATE IF YOU ARE A COLLEGE STUDENT)
	SELF				

1. **IF YOU REPORTED ZERO TOTAL INCOME, HOW ARE YOU BEING SUPPORTED?** _____
2. WHAT STATE DID YOU RESIDE IN AT THE TIME OF YOUR VISIT? _____
3. HAVE YOU APPLIED FOR MEDICAID OR ANY OTHER COUNTY ASSISTANCE? ☐ NO YES (DATE/STATE_____)
4. DID YOU HAVE HEALTH INSURANCE ON THE DATE OF SERVICE? ☐ NO YES (PROVIDE COPY OF CARD WITH THIS APPLICATION)
5. WAS THE DATE OF SERVICE RELATED TO AN AUTO ACCIDENT? ☐ NO YES (INSURANCE NAME/CLAIM#_____)
6. DOES ANYONE IN YOUR HOME HAVE A CHECKING OR SAVINGS ACCOUNT? ☐ NO YES (VALUE_____)
7. DOES ANYONE IN YOUR HOME HAVE ANY OTHER ASSETS? ☐ NO YES (TYPE/VALUE)_____)
8. DO YOU OWN OR RENT A HOME? ☐ OWN RENT OTHER (_____)

FOR INCOME ASSETS LISTED ABOVE YOU MUST PROVIDE THE FOLLOWING FOR EACH MEMBER OF THE HOUSEHOLD:

(Please check items attached)

- ☐ EMPLOYMENT = 3- OR 12-MONTH INCOME
- ☐ UNEMPLOYMENT = BENEFIT LETTER
- ☐ SOCIAL SECURITY = BENEFIT LETTER
- ☐ PENSION OR DISABILITY= BENEFIT LETTER
- ☐ SELF EMPLOYMENT = COMPLETE TAX FORMS INCLUDING SCHEDULE C
- ☐ CHILD SUPPORT = COURT ORDERED DOCUMENT
- ☐ OTHER= PROOF OF ANY OTHER INCOME SUCH AS DIVIDENDS, INTEREST, RENTAL INCOME
- ☐ CHECKING / SAVINGS = CURRENT 30-DAY STATEMENT FOR EACH ACCOUNT

CERTIFICATION: *BY SIGNINGTHIS DOCUMENT, I AFFIRM THE ANSWERS ON THIS APPLICATION ARE TRUE. SHOULD A SUBSEQUENT REVIEW OF AN INDIVIDUAL'S FINANCIAL ASSISTANCEAPPLICATION REVEAL THAT INFORMATION PROVIDED BY THE INDIVIDUAL WAS EITHER INCORRECT OR FRAUDULENT, THE DECISION TO PROVIDE FINANCIAL ASSISTANCE MAY BE REVERSED AND THE RESPONSIBLE PARTY WILL BE BILLED. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECTTO VERIFICATION BY MY CARE PROVIDER, INCLUDING CREDIT REPORTINGAGENCIES, AND SUBJECT TO REVIEW BY FEDERAL AND/OR STATE AGENCIES AND OTHERS AS REQUIRED.*

PATIENT SIGNATURE:_____**DATE:** _____

APPLICANT OR REPRESENTATIVE SIGNATURE:_____**RELATIONSHIP:**_____**DATE:**_____
(IF NOT PATIENT)

MAIL COMPLETED APPLICATION AND DOCUMENTATION TO:
Bon Secours Mercy Health Transportation Billing
2200 Jefferson Avenue
Toledo, OH 43604

Last Revision: 12/2024