FIRELANDS
Regional Medical Center

FINANCIAL ASSISTANCE APPLICATION

(turn page over)

PATIENT NAME:_____________________________ **DATE OF BIRTH:**___________ **DATE:** ____________

APPLICANT NAME: ____

(*If Applicant is not the patient, answer the following questions as they apply to the patient)*

STREET: ____ **CITY:** __________________________

STATE: _______________ **ZIP CODE:** _________________ **PHONE:**______________________________

Accounts **Dates of Service** **$ Dollar Amount**

____ **D Inpt. D Outpt. D ER**

____ **D Inpt. D Outpt. D ER**

____ **D Inpt. D Outpt. D ER**

____ **D Inpt. D Outpt. D ER**

____ **D Inpt. D Outpt. D ER**

Did you have Health Insurance at the time of your hospital service? **D Yes D No**

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

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

Were you an Ohio Resident at the time of your hospital service? **D Yes D No**

If you answered Yes to any question, please attach a copy of your Insurance, Medicaid, or DA card to this application.

For HCAP purposes immediate family includes patient, patient's spouse and all the patient's children under 18 (natural and adoptive) who live in the patient's home. If the patient is under age 18, the family shall include the patient, the patient's natural or adoptive parent(s) and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Name (List Patient also)	Age	Relationship to Patient	Income 3 months prior	Income 12 months prior	Type of Income Verification

Total family members:____________________________ **Total family income:**______________________________

****Explain how you are living financially if claiming 0 income:** ____

____

****Proof of Income must accompany this application for the appropriate time period (3 or 12 months prior to hospital service****

RETURN TO: Firelands Regional Medical Center, 1111 Hayes Ave., Sandusky, OH 44870 Attn: Financial Counseling

****Signature:** ____ **Date:**____________________**

Hospital Use Only:

Approved _____ Denied _____ Reason:____

Financial Counselor: ____ Date:_____________Review: ______________

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FIRELANDS Regional Medical Center

FINANCIAL ASSISTANCE APPLICATION continued....... VERIFICATION SHEET

PATIENT NAME: ____

X if you have any of these	INCOME		Please Provide This VERIFICATION
	W2 / TAXES		1040 FORM WITH W2
	PAYSTUBS		LAST PAYSTUB FOR EACH FAMILY MEMBER WORKING
	SOCIAL SECURITY		SS LETTER SHOWING GROSS AMOUNT
	PENSION / RETIREMENT		DOCMENT SHOWING GROSS AMOUNT
	VA DISABILITY		DOCUMENT SHOWING GROSS AMOUNT
	UNEMPLOYMENT		DOCUMENT SHOWING GROSS AMOUNT
	SELF EMPLOYMENT		DOCUMENT SHOWING INCOME AND BUSINESS EXPENSES
	RENTAL INCOME		DOCUMENT SHOWING GROSS RENTAL INCOME
	CHILD SUPPORT / ALIMONY		DOCUMENT SHOWING GROSS AMOUNT
	OTHER INCOME		PROVIDE VERIFICATION
	RESOURCES	**VALUE**	**PLEASE PROVIDE THIS VERIFICATION**
	CASH		AMOUNT
	BANK ACCOUNTS		CURRENT STATEMENT FOR EACH ACCOUNT
	STOCKS, BONDS, CD, TRUST		DOCUMENT SHOWING VALUE
	IRA / 401K		DOCUMENT SHOWING VALUE
	VEHICLES / CAMPER / BOAT		REGISTRATION OR TITLE
	TOTAL		
	LOANS / DEBT / MEDICAL BILL		DOCUMENT SHOWING AMOUNT OWED
ADJ. TOTAL			**REVIEW /**