Dear Patient,

The Christ Hospital understands that hospital medical expenses can create unexpected financial hardship for patients and their families. We offer several financial assistance programs designed to help relieve this burden.

Please complete and sign the enclosed application for financial assistance. **In order for the application to be complete all questions must be answered, if non-applicable mark 'NA'.** We also request proof of household income for the twelve months prior to your date of service, verification of assets, and proof of residency. Examples of acceptable documentation include:

- **Pay Stubs** – 3 pay-stubs prior to your date of service reflecting the year-to-date gross income.
- **Tax Return** – If you are claiming to be self-employed, we will require a copy of your Schedule C along with a copy of page 1 of the Federal Income Tax return that reflects filing status, dependents claimed, and adjusted gross income.
- **Social Security/Pension** – A copy of your annual Award Letter and Bank Statement showing the direct deposit. The bank statement must include: Bank Name, Patient Name, deposit, and balance in account.
- **Workers Compensation and Unemployment** – Award Letters with the name and dates must be provided.
- **No Income** – If you have no income, please provide a sworn statement from the person providing you basic financial support validating your lack of income. Also include proof of residency for the person providing support.
- **Proof of Residency** – Proof of residency is required for participation in the financial assistance program HCAP. Proof would include: drivers' license, utility bill within 60 days of the medical date of service, rent receipts, mortgage statement, property tax bill or receipt, letter from company or shelter providing living arrangement and credit report.
- **Asset Verification** – Please provide a statement for each asset listing including Bank, Patient Name, and Asset amount.

Please note: If any portion of the application is incomplete or proof of income is not included, we will be unable to process your application.

If you have additional questions or need assistance in completing this application, please call 513-263-9197 and a Christ Hospital Patient Financial Services Representative will be available to speak to you during business hours.

Sincerely,
Patient Financial Services

RETURN APPLICATION TO:

THE CHRIST HOSPITAL
ATTN: FINANCIAL ASSISTANCE APPLICATION
2139 AUBURN AVENUE
CINCINNATI, OH 45219

Application for Financial Assistance

1. Today's Date:_____

2. Patient's Name:_____

3. Responsible Party:_____

4. Street Address:_____

5. City:_____

State:_____ Zip Code:_____

6. Social Security Number:_____-_____-_____

7. Date of Birth:___/___/_____ 8. Patient Sex:_____

9. Home Phone:_____

10. Work Phone:_____

11. Date of Medical Service:____/____/____ - ____/____/____

12. Marital Status:_____

13. Name of Spouse:_____

14. Were you an Ohio resident at the time of the medical service? ☐ Yes ☐ No

15. Were you a United States citizen at the time of the medical service? ☐ Yes ☐ No

16. Did you have health insurance at the time of the medical service? ☐ Yes ☐ No

17. Were you an active recipient of Disability Assistance or Medicaid at the time of the medical service? ☐ Yes ☐ No

18. Name of Insurance Company:_____

Policy #:_____ Group #:_____

Insurance Phone #:_____ Medicaid or Disability #:_____

19. Please list all family members (including yourself). Family members include the applicant, spouse and children (natural or adoptive) under the age of 18 living in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security/Pension benefits, alimony, public assistance, self-employed, etc. Income also includes rent or living expenses that are being provided for you.

Family Member	Age	Relationship to Patient	Income Source	Income for 3 months prior to date of service	Income for 12 months prior to date of service
1.					
2.					
3.					
4.					
5.					
6.					

Total 3 Month Income: $_____ **Total 12 Month Income**: $_____

If you reported $0.00 income above, please have the Support Statement on the next page completed by the person(s) helping to support you and/or your family.

SUPPORT STATEMENT

For applicants who stated zero income, the person(s) providing you with basic financial support must provide a brief explanation as to how you are being financially supported. List services, if any, that you are receiving from patient for providing this support.

_____

_____

_____

_____

I certify that all of the information provided is true and correct to the best of my knowledge. The support person must provide proof of providing residency within 60 days from the medical service date. My signature does not obligate me to provide any financial support related to the medical service of the applicant.

_____ _____

Signature of person providing financial support to applicant **Address of the responsible party**

_____

City, State **Zip Code**

20. **Family Resources/Assets**:

Checking Account Balance: $_____ IRA/401K/403B: $_____

Savings Account Balance: $_____ Rental Property Value: $_____

Healthcare Savings/Flexible Spending Account: $_____

21. **Monthly Expenses**:

Housing: $_____ Credit Cards: $_____

Automobile: $_____ Phone: $_____

House/Car Insurance: $_____ Other (be specific): $_____

Utilities (gas, electric, water): $_____ Other (be specific): $_____

Health Insurance: $_____ Other (be specific): $_____

Medical: $_____ Other (be specific): $_____

Total Monthly Expenses: $_____

I certify that the information provided by me in this application is correct and true to the best of my knowledge. I understand that if I give false information or withhold information, assistance may be denied or reversed at the discretion of The Christ Hospital.

Patient/Guarantor Signature: _____ **Date**: _____

----------This Space is for Hospital Personnel----------

Application Reviewed By: _____ Date Reviewed: _____