Please find enclosed The Christ Hospital Health Network Financial Assistance Application. To apply for financial assistance, and for us to process this application, we will need information from you. We require the following:

- Proof of Income
    - 3 check stubs (including payroll, social security, worker's compensation, unemployment compensation, or other) within 4 weeks from the date of your clinical service. This applies to you and to your spouse, if you are married.
    - If you claim no income we will need a sworn statement from the person providing you with basic financial support in order to validate the lack of income. In this case we will also require proof of your residency with the person providing financial support dated within 60 days of the clinical service.
- Proof of Residency
    - Valid driver's license or
    - Utility bill dated by the issuer within 60 days of the clinical service date.

In addition to the above information we require that you complete the questionnaire and application form enclosed. Please return the completed application, and include the documentation listed above in the enclosed envelope. Without this information we are unable to complete a determination of whether you qualify for financial assistance. Thank you in advance for your cooperation.

Please note that while your Financial Assistance Application is under review you will continue to receive billing statements. Please allow up to 30 days for your application to be reviewed. Thank you for choosing The Christ Hospital Health Network for your healthcare needs. Additionally any financial assistance that is determined for the patient will apply to services rendered and billed by The Christ Hospital and The Christ Hospital Physicians. This does not cover services rendered by some independent providers that may provide services at The Christ Hospital including, but not limited to Anesthesia Associates, Professional Radiology, Greater Cincinnati Pathology, or Team Health ER Physicians.

Should you have any questions or concerns please contact the Customer Service Department at 513-263-8587.

APPLICATION FOR FINANCIAL ASSISTANCE

C0008

PLEASE PRINT:

Todays Date: _____ Medical Date of Service _____

Patient Name: _____
Last First Middle

Responsible Party _____
Last First Middle

Patient Address _____
Street Apt #

_____
City County State Zip

Home Phone _____ Work: _____

Patient Social Security Number _____

Patient Date of Birth _____
Month/Date/Year

Date of Medical Service _____
Month/Date/Year

Were you an Ohio Resident at the time of the medical service? Yes _____ No _____

Did you have health insurance at the time of your medical service? Yes _____ No _____

Were you an active recipient of Disability Assistance or Medicaid at the time of your medical service? Yes _____ No _____

If you answered "Yes" to any of the previous three questions please attach a copy of your insurance card (front and back), Medicaid, or Disability card to this application and complete the following section:

Name of Insurance Company _____

Policy # _____ Group # _____

Insurance Phone Number _____

Medicaid or Disability # _____

Below please indiacte the most recent 12 month's worth of income for all members of the patient's family that live with the patient.

Income includes gross (before taxes) wages, rental income unemployment compensation, social security payments, public assistance, etc. Income also includes rent or living expenses others provide for the patient.

Family Member	Age	Relationship to Patient	Income Source	Income Most Recent 12 Months
Totals				

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

For applicants who stated zero income the person 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 the 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 services of the applicant.

Signature of the person providing financial support to the applicant _____

Address of the responsible party _____

_____

By my signature below, I certify that I have carefully read this application and that everything I have stated or provided in any attachment is true and correct to the best of my knowledge. I understand that it is unlawful to knowingly submit false information to obtain financial assistance. I further understand that other parties may rely on this information and I hereby authorize them to do so.

Patient/guarantor signature _____ Date _____