THE BELLEVUE HOSPITAL

Quality Care, Close To Home

Financial Assistance Application Form

PATIENT NAME:_____ **DATE:**_____

APPLICANT NAME, IF NOT PATIENT:_____

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

PATIENT BIRTH DATE:_____**STREET ADDRESS:** _____

CITY, STATE, ZIP CODE:_____**PHONE:**_____

	From	**To**	**Visit# /Hospital Ref #**	**$ Dollar Amount**			
Date of Service:	_____	_____	_____		**Inpatient**	**Outpatient**	**ER**

(An 'eligible' service date includes out-patient services for 90 days immediately following the first approved day.)

Did you have health insurance at the time of your hospital service? **Yes____No_____**

Were you an active recipient of Ohio Disability Assistance at the time of your hospital service? **Yes_____No____**

(*If you answered Yes to this question, please attach a copy of your DA card effective for above date of service)*

Were you an active Medicaid recipient at the time of your hospital service? **Yes____No____**

If yes, Medicaid recipient ID number: _____

Were you an Ohio resident at the time of your hospital service? **Yes____No____**

Please provide the following information for all of the people in the patient's immediate family who live in the patient's home. If the patient is under the age of 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. ***Complete requested data based on conditions at date of service.***

Family Member Name	**Age**	**Relationship to Patient**	**GROSS Income for 3-month period prior to date of service**	**GROSS Income for 12-month period prior to date of service**	**Type of Income**
(Patient)		(Self)			
Total persons in family:		**Total Family Gross Income:**			

***If you reported $ 0 income you must provide a brief explanation of how you are living financially.**

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FAILURE TO PROVIDE ALL INFORMATION WILL CAUSE YOUR APPLICATION TO BE RETURNED TO YOU UNPROCESSED.

Mail to : The Bellevue Hospital, PO Box 8004, Bellevue, OH 44811. Attn: Financial Counseling.

By my signature below, I certify everything I have stated on this application and on attachments is true.

_____ _____

Applicant Signature **Date**

Hospital Use Only

Approved____Denied_____HCAP____BCA___@_____% adjustment Denial Reason_____

Financial Counselor_____Date_____Reviewed By_____

REV 01/2019