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SUBMITTED BY: _____

DILEY RIDGE MEDICAL CENTER

KALA SHAANDHAYNTA CODSIYADA TAAKULAYNTA DHAQAALE

Magaca Bukaanka _____ Xaaladdaada Xaas Ahaaneed _____

Cinwaankaaga oo Dhan _____ Taleefanka _____

Sooshal Sakuuridka # _____ Lambarka Xisaabtaada _____ Taariikhda Adeegga _____

Waa inaad codsigaaga ku sameeysaa 6 bilood gudahood laga bilaabo taariikhda adeegga ama taariikhda qaansheegashada ugu horreeysa ee isbitaalka caawinaaddiisa dhaqaalaha

Xilligii adeegga laguu qabtay ma degganayd gobolka Ohio?	☐ Haa ☐ Maya	Xilliga adeegga laguu qabtay ma qaadanaysay dhaqaalaha laysku siiyo naafanimada?	☐ Haa ☐ Maya
Hadda gobolka Ohio ma deggantahay?	☐ Haa ☐ Maya	Xilligii adeegga laguu qabtay xaq ma u lahayd Medcaid, Medicaid eey weheliso Spend Down, Caresource, ama Molina?	☐ Haa ☐ Maya
Gobolka Ohio ma waxaad u deggan tahay oo keliya inaad ka hesho daryeel caafimaad?	☐ Haa ☐ Maya	Xilliga adeegga laguu qabtay ma lahayd caymis kale?	☐ Haa ☐ Maya
Qola kale ee lagu dallici karo deeyntaan ma jirtaa? Hadii jawaabtu haa tahay, Magacooda _____ Taleefanka lagala xariirikaro # _____	☐ Haa ☐ Maya	**Haddii suaaalaha middod ku jawaabtay haa, fadlan soo dir nuqulka caymiskaaga ama wax xaqiijinaaya si aan ugu dallacno kharashka qolada ku haboon.	

Soo liisgaree saygaaga iyo magacyada ilmaha aad dhashay amaseba aad soo korsatay ee dadoodu ka yartahay 18 sano ee adiga kula deggan amaba aan kula deggaanayn.

Magaca	Da'da	Kula deggan	Xiriirkiinna qaraabannimo
		☐ Haa ☐ Maya	
		☐ Haa ☐ Maya	
		☐ Haa ☐ Maya	

Hadduusan bukaanku qaangaar ahayn, beddelka bukaanka iyo sayga fadlan soo gudbi labada waalid hooyada iyo aabahaba dakhligooda dhaqaale

DAKHLIGA GUUD (CASHUURTA KA HOR)	Waalid/Hooyo/Masuul ka	Say/Aabe
3 bilood ka hor taariikhda adeegga dakhliga OO DHAN.	$	$
12 bilood ka hor taariikhda adeegga dakhliga OO DHAN.	$	$
Waa maxay dakhligaad filaneeyso OO DHAN bishaan markeey dhammaato?	$	$
Soo gudbi bilaha soo socda dhakhligooda iyo meeshaad ka fileeyso dakhligaas	$	$
Haddii dakhligaad soo gudbisay uu yahay “$0” fadlay iyadoo gaaban soo qor adigoo noo fasiraaya sida noloshaada aad u maareeyso.		

KHARASH

Ijaar/mortgage	$	$
Kharash caafimaad/Daawo laguu qoray	$	$

HANTI

Ma leedahay gurigaad deggan tahay ama mid kaleba?	☐ Haa ☐ Maya Qiimaha $
Xisaabtaada bangiga/Lacagta kuu taal?	☐ Haa ☐ Maya Qiimaha $

Waxaan caddeeynayaa in macluumaadka kor ku qoran run iyo sax yihiin anigoo la kaashanaaya sida ugu wanaagsan ee aan u ogahay iyo weliba ineey Diley Ridge Medical Center u taal soo xaqiijinteeda. Waxaan kaloo ogsoonahay in la i warsan karo caddayn dakhliga iyo/ama hantida ineey la socoto dalabkaan. Wixii khuseeya isbitaalka barnaamijkiisa caawinaadda dhaqaale, waxaan u fasaxayaa Diley Ridge Medical Center wixii qaabilsan waxa loo yaqaan credit bureau report(s) si loo xaqiijiyo macluumaadkaan. Sidoo kale waxaan garoowsanahay haddii macluumaadkaani eey beenoobaan, inaan anigu u qoollanahay bixinta adeegyada. Fadlan soo raaci warqad faah faahineeysa wixii dheeraad ah ee aan caadi ahaayn.

Saxiixa _____ Taariikh _____

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DILEY RIDGE MEDICAL CENTER

FINANCIAL ASSISTANCE SCREENING APPLICATION

Patient Name _____ Marital Status _____

Complete Address _____ Phone # _____

Social Security # _____ Account # _____ Date of Service _____

You must apply within 6 months of the date of service or date of first bill for Diley Ridge Medical Center financial assistance.

Were you a resident of Ohio at the time of service?	☐ Yes ☐ No	Were you an active recipient of Disability Assistance at the time of your hospital service?	☐ Yes ☐ No
Are you currently a resident in Ohio?	☐ Yes ☐ No	Were you eligible for Medicaid, Medicaid with a Spend Down, Caresource, or Molina on this date of service?	☐ Yes ☐ No
Are you residing in Ohio for the sole purpose of receiving health care?	☐ Yes ☐ No	Did you have insurance coverage for this date of service?	☐ Yes ☐ No
Is or will any other entity be held responsible/pursued for this debt? **If yes,** Name _____ Contact # _____	☐ Yes ☐ No	**If you marked **yes** to any of the questions above, please send copies of your insurance cards or other proof of coverage so that we may bill them appropriately.	

List your spouse and your natural or adopted children that are under the age of 18 who reside in/outside the home.

Name	**Age**	**Reside in home**	**Relationship**
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

If the patient is a minor, please provide both the mother and father's income in place of patient and spouse.

GROSS INCOME (Before taxes)	Patient/Mother/Legal Guardian	Spouse/Father
3 months prior to date of service **TOTAL** income.	$	$
12 months prior to date of service **TOTAL** income.	$	$
What will you **TOTAL** expected income be by the end of this month?	$	$
List any other monthly income and **the source** of that income	$	$
If reported income is "$0" please provide a brief statement to explain how your normal living expenses are provided for.		

EXPENSES

Rent/mortgage	$	$
Medical bills/prescriptions	$	$

ASSETS

Own primary residence or other property	☐ Yes ☐ No Value $
Bank accounts/balance	☐ Yes ☐ No Value $

I attest that the above information is true and correct to the best of my knowledge and is subject to confirmation by Diley Ridge Medical Center. I understand that I may be asked for documented proof of income and/or assets to accompany this application. For the purposes of the hospital assistance program, I authorize Diley Ridge Medical Center to access my credit bureau report(s) to confirm this information. I also understand that if the information is determined to be false, I will be liable for payment of services. Please attach a letter explaining any extraordinary circumstances.

Signature _____ Date/Time _____