SUBMITTED BY: .

FINANCIAL ASSISTANCE SCREENING APPLICATION

DILEY RIDGE MEDICAL CENTER

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	Spouse
3 months prior to date of service **TOTAL** income.	$	$
12 months prior to date of service **TOTAL** income.	$	$
What will your **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.

Click to Sign

Signature X

Date/Time

Select One Go