BERGER HEALTH SYSTEM FINANCIAL AID APPLICATION

DATE: __________________ PATIENT NAME: ____

GUARANTOR NAME, if not patient_____________________________________ PHONE:____________________

MAILING ADDRESS:____

CITY, STATE, ZIP: ____

DATE(S) OF HOSPITAL SERVICE: ____
(Date of service must be within three (3) years of application date)

COMPLETE THE QUESTIONS BELOW:

1. Were you an Ohio resident at the time of your hospital services? ❑Yes ❑No
2. Do you have health insurance? ❑Yes ❑No
3. Were you an active recipient Disability Assistance at the time of hospital service? ❑Yes ❑No
4. Were you an active Medicaid recipient at the time of your of your hospital service? ❑Yes ❑No
5. Is any member of your household currently pregnant? ❑Yes ❑No

If you answered yes to any of these questions, please attach a copy of your insurance card, DA card or Medicaid card.

Please provide the following information for all of the people in your immediate family who live(d) in your home during the date of service. For purposes of HCAP, Family is defined as the patient, the patient's spouse and all of the patient's children, natural and adoptive, under the age of eighteen regardless of whether they live in the patients home. **If the patient is under the age of eighteen, the family shall include the patient, the patient's natural or adoptive parent(s) and the parent(s) children, natural or adoptive under the age of eighteen regardless of whether they live in the home.**

Name	Age at time of Service or DOB	Relationship to patient	Income for 3 months prior to hospital service*	Income for 12 months prior to hospital service*	Type of income verification attached
		Self			
Total Persons in family		**Total Family Income**			

* Income verification, if required by the hospital, may include pay stubs, w-2s or 1099, statement from employer, award letter, or other documents containing income information for the appropriate time period (3 or 12 months prior to hospital service). We are unable to accept income taxes for proof of income.

****If you have reported $0 income, please provide a brief explanation of how you (or the patient) are surviving financially. Please use an attached sheet if necessary.**

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By my signature below, I certify that everything I have stated on this application and on any attachments is complete and accurate.

____ ________________________

Applicant Signature **Date**

OFFICE USE ONLY

HCAP: _____

Date of Financial Aid Application: ________________ Charity Care: _____

Denied/ Over Income: _____

Patient Name: ____

Address: ____

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Total Annual Income __________________Family Size: ______ Poverty Level Income: __________________FFA Signed:______

Name:						
Account:						
Date of service:						
Admit type:						
Insurance:						
Discount %:						
S/P Balance $:						
Non-billable charges $:						
Discount $:						
Pt. Owes $:						
Processed by:						
Date processed:						
Approved by:						

Income Verification:

- ☐ Patient Statement
- ☐ Bank Statement
- ☐ Tax Return, Year______
  (for prior year DOS only if no other form of income verification is available)
- ☐ Current Award Letter
- ☐ Pay Stubs
- ☐ Other_________________

Total Monthly Income x 3	
Total Quarterly Income x 4	
Income Total	

Comments:

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