Madison HEALTH

Application for the Financial Assistance Program

ATTACHMENT E

PATIENT NAME: _____ DATE OF APPLICATION: _____

APPLICATION NAME, IF NOT PATIENT: _____

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

STREET: _____ CITY: _____

STATE: _____ ZIP CODE: _____ CONTACT PHONE: _____

DATE(S) OF HOSPITAL SERVICE: From_____ To _____

✓	Were you an Ohio resident at the time of your hospital service?	Yes ____	No ____	**Account numbers:**
✓	Do you live in Madison County?	Yes ____	No ____	_____
✓	Were you an active Medicaid recipient at the time of your hospital service? *If yes, Medicaid recipient ID number:*	Yes ____	No ____	_____ _____ _____
✓	Were you an active recipient of Disability **Assistance at the time of your hospital service?** *(If you answered Yes to this question, please attach a copy of your DA card effective during your hospital service to this application.)*	Yes ____	No ____	_____ _____
✓	Did you have health insurance (other than Medicaid) at the time of your hospital service?	Yes ____	No ____	

Number in Family	Income	Number in Family	Income	Number in Family	Income
1	$12,060	4	$24,600	7	$37,140
2	$16,240	5	$28,780	8	$41,320
3	$20,420	6	$32,960		

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of MH-FAP, "family" is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home.

Name	Age	Relationship to Patient	Income for 3 months prior to hospital service *	Income for 12 months prior to hospital service *	Type of income verification attached **-***
(Patient)		Self			
Total persons in family		Total family income			

*Income verification may accompany this application if available; if you reported $0 income provide a brief explanation below:

**Income verification may include income tax returns, pay stubs, W-2's or other documents containing income information for the appropriate time period (3 or 12 months prior to hospital service).

*** If self-employed include your 1040 and Schedule C forms with application.

By my signature below, I certify that everything I have stated on this application and on any attachments is true and is subject to verification

_____ _____

Applicant Signature Date PFS Director or Patient Access Manager Date