FINANCIAL ASSISTANCE APPLICATION
Institute for Orthopaedic Surgery

DATE OF SERVICE: _____ ACCOUNT NUMBER: _____

PATIENT OR APPLICANT NAME: _____ADDRESS: _____
_____CITY: _____STATE: _____
ZIP: _____HOME PHONE NUMBER: _____CELL PHONE NUMBER: _____
PATIENT SOCIAL SECURITY NUMBER: _____MARITAL STATUS: _____

THE FOLLOWING QUESTIONS MUST BE COMPLETED FOR FINANCIAL ASSISTANCE CONSIDERATION

1. **WERE YOU AN OHIO RESIDENT AT THE TIME OF YOUR HOSPITAL SERVICE?** YES _____ NO _____
   a) IF "NO", WHAT STATE DID YOU RESIDE? _____
2. **HAVE YOU APPLIED FOR MEDICAID OR OTHER COUNTY ASSISTANCE?** YES_____ NO_____
   a) IF "YES", WHAT DATE DID YOU TURN IN APPLICATION? _____
   b) IF "YES", DID YOU APPLY FOR MEDICAID IN A STATE OTHER THAN OHIO? YES_____ NO_____
   IF "YES", WHAT STATE DID YOU APPLY FOR COVERAGE? _____
3. **DID YOU HAVE HEALTH INSURANCE COVERAGE(S) ON THE DATE OF SERVICE?** YES_____ NO_____
   a) IF "YES", (AND THE INSURANCE HAS NOT BEEN BILLED) PLEASE SEND A COPY OF YOUR INSURANCE CARD(S) WITH THIS APPLICATION.
4. **WAS THE DATE OF SERVICE RELATED TO AN AUTO ACCIDENT?** YES_____ NO_____
   a) IF "YES", DID YOU FILE A CLAIM? CLAIM NUMBER: _____INSURANCE NAME: _____
5. **DO YOU HAVE A HEALTH SAVINGS ACCOUNT (HSA)?** YES_____ NO_____
   a) IF "YES", PLEASE SEND COPY OF DOCUMENTATION SHOWING YOUR CURRENT BALANCE.
6. **PLEASE INDICATE IF ANYONE IN YOUR HOME HAS THE FOLLOWING RESOURCES.**
   a) DO YOU OWN OR RENT YOUR HOME? OWN_____RENT_____
   b) CHECKING/SAVINGS: YES_____ NO_____ IF "YES" LIST TOTAL VALUE $_____
   c) OTHER ASSETS INCLUDING BUT NOT LIMITED TO CD'S/STOCKS/BONDS/MONEY MARKET ACCOUNTS: YES_____NO_____
   IF "YES" LIST TOTAL VALUE $_____

PLEASE LIST EVERYONE IN YOUR HOUSEHOLD UNDER THE AGE OF 18 BELOW. IF YOU NEED ADDITIONAL SPACE, PLEASE ATTACH ADDITIONAL FORM

NAME	RELATIONSHIP TO PATIENT	Date of Birth	TOTAL INCOME IN THE 3 MONTHS PRIOR TO DATE OF SERVICE	TOTAL INCOME IN THE 12 MONTHS PRIOR TO DATE OF SERVICE	INCOME SOURCE EMPLOYER NAME (STATE IF COLLEGE STUDENT)
	SELF				

SEND PROOF OF 3 MONTH OR 12 MONTH INCOME WITH THIS APPLICATION:

INCOME IS CONSIDERED TO BE TOTAL INCOME *BEFORE* TAXES ARE TAKEN OUT, AND INCLUDES BUT IS NOT LIMITED TO: • EMPLOYMENT WAGES OR SALARIES (SEND 3 MONTHS OF PAY STUBS) • UNEMPLOYMENT • ALIMONY • VA BENEFITS • SOCIAL SECURITY (BEFORE DEDUCTIONS) OR AWARD LETTER • CHILD SUPPORT • PENSION OR RETIREMENT • 401K • WORKERS COMPENSATION AWARD LETTER • LUMP SUM PAYMENTS • OWF ASSISTANCE • ANNUITIES • CASH RECEIPTS • SELF EMPLOYMENT RECORDS • ODD JOB(S) • FEDERAL INCOME TAX RETURN •ANY OTHER INCOME • IF YOU ARE REPORTING ZERO INCOME YOU MUST COMPLETE THE SUPPORT STATEMENT BELOW TO BE CONSIDERED FOR FINANCIAL ASSISTANCE • PROOF OF CHECKING/SAVINGS (OR OTHER ASSETS) MAY BE REQUESTED • FOOD STAMPS ARE NOT COUNTED AS INCOME BUT SHOULD BE LISTED ON "SUPPORT STATEMENT"LINE BELOW

IF YOU REPORTED ZERO TOTAL INCOME, HOW ARE YOU BEING SUPPORTED? _____

CERTIFICATION: *BY SIGNING THIS DOCUMENT, I AFFIRM THE ANSWERS ON THIS APPLICATION ARE TRUE. SHOULD A SUBSEQUENT REVIEW OF AN INDIVIDUAL'S FINANCIAL ASSISTANCE APPLICATION REVEAL THAT INFORMATION PROVIDED BY THE INDIVIDUAL WAS EITHER INCORRECT OR FRAUDULENT, THE DECISION TO PROVIDE FINANCIAL ASSISTANCE MAY BE REVERSED AND THE RESPONSIBLE PARTY WILL BE BILLED. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY MY HOSPITAL PROVIDER, INCLUDING CREDIT REPORTING AGENCIES, AND SUBJECT TO REVIEW BY FEDERAL AND/OR STATE AGENCIES AND OTHERS AS REQUIRED. I AUTHORIZE MY EMPLOYER TO RELEASE TO MY HOSPITAL PROVDER MY PROOF OF INCOME.*

PATIENT SIGNATURE: _____DATE:_____

APPLICANT OR REPRESENTATIVE SIGNATURE: _____RELATIONSHIP:_____DATE:_____
(IF NOT PATIENT)

MAIL COMPLETED APPLICATION AND DOCUMENTATION TO:
Institute for Orthopaedic Surgery
Attn: Billing Department
801 Medical Drive, Suite B
Lima, Ohio 45804