# Patient Application for Financial/Medication Assistance

Kettering Health Main Campus, Kettering Health Miamisburg, Kettering Health Dayton, Kettering Health Washington Township, Kettering Health Greene Memorial, Soin Medical Center, Kettering Health Hamilton, Kettering Health Behavioral Medical Center and Kettering Health Troy

## PART 1: PATIENT INFORMATION (REQUIRED)

Complete patient information listed below.

Date of hospital service _____

Patient name _____ Date of birth _____

Address _____

City _____ State _____ Zip code _____ Phone number (_____) _____

Have you applied for Medicaid benefits within the last 90 days? ☐ Yes ☐ No

Were you an Ohio resident at the time of your hospital service? ☐ Yes ☐ No

Were you an active Medicaid recipient at the time of your service? ☐ Yes ☐ No

Were you an active recipient of Disability Assistance at the time of service? ☐ Yes ☐ No

Marital status: ☐ Married ☐ Divorced ☐ Widow(er) ☐ Single ☐ Domestic partner

## PART 2: FAMILY SIZE (REQUIRED)

List family size and include all household members name, date of birth, age, and relationship.

Household size _____ (including yourself, your spouse/domestic partner, all dependents, and other members of the household)

Spouse/domestic partner name _____ Date of birth _____

Provide the following information for all household members and their relationship as HCAP and Kettering Health Charity calculate family size in different ways. (Only married, natural born, or adopted relatives will qualify for an HCAP household.)

| Name | Date of birth | Age | Relationship |
|---|---|---|---|
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Kettering HEALTH

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**PART 3: FAMILY INCOME (REQUIRED)**

Provide monthly gross income for yourself, your spouse/domestic partner, and all other family members for 3 months and/or 12 months prior to date of hospital service. Proof of income documentation accepted: check stubs, tax return/1099/W2's, social security/pension/VA statements, court documents, and other documents for income proof as reported below.

| Household Income | Patient | Spouse/Domestic Partner | Dependent 18-20 years | Parent or Caretaker |
|---|---|---|---|---|
| Employment income | | | | |
| Gross social security income | | | | |
| Pension/retirement | | | | |
| VA benefits | | | | |
| Temporary disability income (TDI) | | | | |
| Unemployment benefits | | | | |
| Alimony | | | | |
| Child support | | | | |
| Other (describe) | | | | |
| **Total monthly income** | **$** | **$** | **$** | **$** |

1. Has there been any changes in your monthly income within the previous 12 months? ☐ Yes ☐ No
2. Total gross family income for the previous 3 months $ _____
3. Total gross family income for the previous 12 months $ _____
4. If reported $0 income, provide a brief explanation of how you are meeting your monthly obligations.

_____

I authorize Kettering Health to submit and/or exchange personal information documentation to pharmaceutical manufacturing companies for the purpose of helping me obtain financial assistance for my medication expenses and certify by my signature below, that everything I have stated on this application is true and accurate to the best of my knowledge.

I understand that the information that I submit is subject to verification by Kettering Health. I understand that if any information I have given proves to be untrue Kettering Health will reevaluate my financial assistance eligibility status and take appropriate action. I understand that additional proof of income may be requested by Kettering Health, and not submitting requested documentation will result in the denial of my application.

Signature of applicant/legal guardian _____ Date _____

*If signed by someone other than the patient, list full name and the reason the patient is unable to sign.*

Forward application and all applicable documents to: **Kettering Health Financial Assistance P.O. Box 933310 Cleveland, OH 44193, Email: *FinancialCounselors@ketteringhealth.org* or fax (937) 522-9944.** For additional questions call: (937) 914-7680