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 Troy, and Kettering Health Behavioral Medical Center

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 (_____) _____

Were you an active Medicaid recipient at the time of your service? ❒ Yes ❒ No
(Applicable to Hospital Care Assurance Program)

PART 2: FAMILY SIZE (REQUIRED)

List family size and include each household member's name, date of birth, age, and relationship to the applicant.

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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PART 3: FAMILY INCOME (REQUIRED)

Provide monthly gross income for yourself, your spouse/domestic partner, and all other family members for three months and/or 12 months prior to date of hospital service. Proof of income documentation accepted: check stubs, tax return/1099/W2s, 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 three 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.