UNIVERSITY OF TOLEDO MEDICAL CENTER
HOSPITAL CARE ASSURANCE APPLICATION

Patient Name: ____________________________ Patient Phone Number: ____________________ Dates of Service: ________________________

Address: ________________________________ Family Member Interviewed: _________________ Add'l Dates of Service: ___________________

City: ___________________________________ Responsible Party: _________________________ Account Numbers: _______________________

State: ______________ Zip Code: _________ Relation to Patient: _________________________ Add'l Acct No's: ________________________

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

Were you covered by health or auto insurance for the date(s) of service? Yes ____ No _____ (If yes, enter information below & attach copy of insurance card)

Name of Insurance Co. ____ Policy # _________________________ Group # _________________

Do you have Medicaid benefits for the date(s) of service? Yes _____ No _____ (If yes, enter billing # ___________________ & attach copy of Medicaid card)

Do you have Disability Assistance (DA) for the date(s) of service? Yes _____ No _____ (If yes, enter billing # _________________ & attach copy of DA card)

Please list all "family" members (including yourself). Family members include parents, spouse & children (natural or adoptive) under the age of eighteen (18) living in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, social security benefits, public assistance, etc. Income verification may be required. A new or updated application is required for each month in which services are provided.

Family Members	Age	Relationship to Patient	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service
1.					
2.					
3.					
4.					
5.					
6.					
7.					
TOTALS					

If you reported $0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested.

Responsible Party Signature: ____ Date Completed: ___________________________________

(Void without responsible party signature)

By my signature above, I affirm to the best of my knowledge and belief that the answers on this application are true. I understand that it is unlawful to knowingly submit false information to obtain government benefits.

Signature obtained by ____ FC ________ Date ________________________________