

**THE UNIVERSITY OF TOLEDO MEDICAL CENTER  
Financial Assistance 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. Please include verification of income from the last 3 or 12 months to expedite processing of your application.**

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.					
<b>TOTALS</b>					

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: \_\_\_\_\_  
 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.

Mail completed application and income documentation to:  
 University of Toledo Attn: Patient Financial Services  
 3000 Arlington Ave. MS 1168  
 Toledo, OH 43614