THE UNIVERSITY OF TOLEDO MEDICAL CENTER

HCAP/PFA

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.					
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: _____

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