# KETTERING HEALTH NETWORK

PATIENT APPLICATION FOR FINANCIAL/MEDICATION ASSISTANCE

Kettering Memorial Sycamore Grandview Southview Greene Memorial Troy

Fort Hamilton Soin/Beavercreek Medical Center Kettering Behavioral Medicine Center

Patient Name _____ Date of Birth_____

Telephone Number _____ Street address_____

City_____ State_____ Zip Code: _____

Date(s) of Hospital Service_____

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 __

REQUIRED: Household size (including yourself, your spouse or domestic partner, all dependents, and other members of the household): _____**Spouse/ domestic partner information:**

Name: _____

Date of Birth: _____

List all household members who need to be considered for financial assistance (see next page to list additional household members if necessary)

Include all household members and their relationship to the patient as HCAP and KHN Charity calculate family size in different ways. (only married, natural born, or adopted relatives will qualify for an HCAP household)

**(Parent) Name: _____Date of Birth: _____(age)_____Relationship: _____**

**Name: _____Date of Birth: _____(age) _____Relationship: _____**

**Name: _____Date of Birth: _____(age)_____Relationship: _____**

**Name: _____Date of Birth: _____(age)_____Relationship: _____**

**Name: _____Date of Birth: _____(age)_____Relationship: _____**

REQUIRED: Monthly Gross Income (all income from household must be reported) Reported income must be for time periods prior to date(s) of hospital service

| Household Income | Patient | Spouse or Domestic Partner | Dependent 18- 20 years | Parent or Care Taker |
|---|---|---|---|---|
| Employment Income | | | | |
| Gross Social Security Income | | | | |
| Pension/Retirement | | | | |
| VA Benefits | | | | |
| Temporary Disability Income (TDI) | | | | |
| Unemployment Benefits | | | | |
| Alimony | | | | |
| Child Support | | | | |
| Other: (describe) | | | | |
| Total Monthly Income | $ | $ | $ | $ |
| | | | | |

REQUIRED:

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 KHN to submit, exchange personal information documentation to pharmaceutical manufacturing companies for 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 the verification by KETTERING HEALTH NETWORK. I understand that if any information I have given proves to be untrue KETTERING HEALTH NETWORK will reevaluate my financial assistance eligibility status and take appropriate action. I understand that I may have to provide Proof of Income as defined by KHN, and not submitting requested documentation will result in the denial of my application.**

**Signature of Applicant_____ Today's date_____**

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

***Complete and forward with income proof to KHN Financial Assistance PO Box 933310 Cleveland, OH 44193***
***Email: FinancialCounselors@ketteringhealth.org Fax: 937-522-9944 Additional questions call: 937-914-7680***