Ashtabula County Medical Center

Cleveland Clinic affiliate

Patient Name: _____

Address: _____ Month of Service: _____ Patient's DOB: _____

City: _____ Phone Number: _____ Patient's SSN: _____

State: _____ Zip Code: _____ Marital Status: Single☐ Married☐ Separated☐ Divorced☐ Widowed☐

Do you have health insurance covering these services? Yes ☐ No ☐ if no, why not? _____

Do you have Medicaid or Medicaid SpendDown? Yes ☐ No ☐ if yes, how much is the SpendDown? $_____

Do you have a Health Savings Account or Flex Plan? Yes ☐ No ☐ if yes, what is the balance? _____

Do you have Disability Assistance (DA) benefits? Yes ☐ No ☐

Is this service a result of an accident? Yes ☐ No ☐

Is this service work related? Yes ☐ No ☐

Are you holding anyone liable for this bill? Yes ☐ No ☐

Are you an Ohio resident? Yes ☐ No ☐

Are you a Citizen of the United States? Yes ☐ No ☐

If you have any questions regarding the application or the information you need to provide, please call the Financial Counselor.

440-997-6219 Monday-Thursday 7:00 to 5:30 Kelly

440-997-6759 Monday –Friday 7:30 to 4:00 Allison

Definition of "Family and Wages"

- Patient's "Family" includes the patient, their parents (if the pt is a minor), their spouses, and natural or adopted children, under the age of 18 and living in the home. Step-children, grandchildren, and foster children are excluded.
- Income includes gross (pretax) wages, rental income, gross income from self-employment, public assistance, social security, unemployment compensation, strike benefits, alimony, child support, military family allotments, pension, and veteran's benefits, etc. Sources of income apply to all applicable family members. **A statement of income for – the 3 months or the 12 months prior to services is required.**

This program covers only hospital charges. It does not cover any bills for a physician or physician group, including your personal physician, anesthesiologist, radiologist or pathologist.

Family Members living in the home at time of service, include the patient (applicant)	Age	Relationship to Patient at time of Service	Source of Income Or Employers Name at time of service	Current Income at Time of Service Previous 3 months x 4	12 months preceding date of service
1.					
2.					
3.					
4.					
5.					
6.					
TOTALS					

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

**_____.

I affirm that the answers on this application are true, and I understand that it is unlawful to knowingly submit false information to obtain government benefits.

Responsible Party Signature: _____ Date Completed: _____

By my signature below, I affirm to the best of my knowledge and belief that the answers on this application are true. I further understand and agree that other parties may rely on the information I provide herein. I hereby authorize them to do so.

Hospital Representative Signature: _____ Date Completed: _____