TriHealth Financial Assistance/HCAP Application

Proof of Income Required with Application

_____ _____

Patient/Guarantor Info Dates of service

_____ _____ _____-_____-_____

Date of Birth Phone Social Security Number

_____ _____ _____ _____

Address City State Zip

Marital Status (circle one): Single Married Separated Divorced Widowed

Do you have health insurance?: YES NO Have you applied for Medicaid? YES NO

If Yes, list the name of your insurance plan: _____

The following information must be provided for all people in your immediate family who live in your home. For purposes of this application, "Immediate Family" is defined as the parent(s), Patient's spouse (regardless of whether they live in the home), and all of the Patient's children under 18 (natural or formal adoption) who live in the Patient's home.

First Name Last Name	Date of Birth	Social Security Number	Relationship to You (Circle one)	Income	Type of Income (LIST ALL) (Wages, Social Security, Retirement, etc.)
			PATIENT	YES NO	
			Spouse Child Parent	YES NO	
			Spouse Child Parent	YES NO	
			Spouse Child Parent	YES NO	
			Spouse Child Parent	YES NO	
			Spouse Child Parent	YES NO	

Please provide proof of income and list total gross **family** income (income before taxes) below:

3 calendar months prior to the date of service: $ _____

12 calendar months prior to the date of service: $_____

If you list your income as $0, please provide a brief explanation regarding how you are being supported to meet your daily needs.

_____

This document is legal and binding. Please include documentation to support the income information you have provided. Your signature attests that, to your knowledge, the information provided is accurate.

_____ _____

Signature **Date**

Account Number(s):

Mail completed application and proof of income to: Financial Assistance, TriHealth Inc., PO Box 639461, Cincinnati, OH 45263-9461

http://www.trihealth.com/tools/pay-your-bill/financial-assistance/