FINANCIAL AID APPLICATION

Bucyrus Hospital • Galion Hospital • Avita Ontario • Avita Physicians

Applicant Name _____
Last *First* *MI*

Street Address _____

City _____ State _____ Zip _____ Phone _____

*Date(s) of Service _____

Account Number(s) _____

1. Is the patient(s) a U.S. citizen? ◯ Yes ◯ No
2. Was the patient(s) an Ohio resident at the time of his/her service? ◯ Yes ◯ No
3. Was the patient(s) an active Medicaid recipient at the time of his/her service? ◯ Yes ◯ No
   If yes, Medicaid recipient ID number(s): _____
4. Did the patient(s) have health insurance (other than Medicaid) at the time of his/her service? ◯ Yes ◯ No
   If yes, provide name of insurance: _____

Provide all of the required information for applicant and everyone who lives in his/her home.

Full Name	Birth Date	Relationship to Applicant	Total Gross Income		
			Source of Income *(e.g. Employment, SSI, Child Support, Alimony)*	3 months before the oldest date of service	12 months before the oldest date of service

If you report $0 or minimal income, provide a brief explanation below on how you are meeting basic living needs, including who provides shelter, food, transportation, utilities, clothing and how long you have been supported by this person(s) and/or agency(s).

INCOME from (all family members)
Check all that apply ***

*** If checked, you will be required to upload/provide supporting documentation*

- ☐ Wages
- ☐ Social Security
- ☐ Veterans Benefits
- ☐ SSI - Disability
- ☐ Railroad Benefits
- ☐ Self-Employment Income
- ☐ Retirement/Pension Benefits
- ☐ Child Support or Alimony
- ☐ Food Stamps
- ☐ Unemployment Compensation
- ☐ Rental Income
- ☐ Dividends/Interest/Royalties
- ☐ Military Family Allotments
- ☐ Estates/Trusts
- ☐ IRA/401K/401B Annuity Payments
- ☐ Workers Compensation
- ☐ Residential Foster Care
- ☐ Other: _____

LIQUID ASSETS (all family members)
Check all that apply ***

- ☐ Cash
- ☐ Savings Accounts
- ☐ Checking Accounts
- ☐ Money Market Accounts
- ☐ Stocks/Bonds/Certificates of Deposit
- ☐ Trust Fund Balance
- ☐ Lottery Winnings (*within 12 mths of service date*)
- ☐ Other: _____

I understand that if I have deliberately given any false information or have withheld any information regarding any situation, I am subject to possible prosecution for fraud. By signing this application, I am authorizing the release of any information needed to determine my eligibility, not to exclude address verification, a credit check through a national credit bureau, asset check through the County Tax Assessor, and verification of all benefits listed.

Signature _____ **Date** _____

If printed, return application to: Patient Financial Services, 700 N Columbus St, Crestline, OH 44827
Call our Customer Service Line with questions or to request assistance completing the application: **419-468-0512**

Applications will be accepted for dates of service up to 240 days from first statement date