AVITA HEALTH SYSTEM

How to Complete the Financial Aid Form

Field Description	Details
Applicant Name	Applicant's Name (please print).
Address/Phone Number	Applicant's Current Address and Phone Number (please print).
Date(s) of Service	Date (or admission date) the patient was seen at the hospital or provider's office.
Account Number(s)	Enter the account number from the statement. If the account number is not available, leave the box blank.
Is the patient(s) a U.S. citizen?	Answer yes or no.
Was the patient(s) an Ohio resident at the time of his/her service?	Answer yes or no. Residency is established by a person who is living in Ohio voluntarily at the time of the hospital service, is not receiving public assistance in another state and did not come to Ohio for the sole reason of having healthcare services
Was the patient(s) an active Medicaid recipient at the time of his/her service?	Answer yes or no. If yes, please list the Medicaid recipient ID number.
Did the patient(s) have health insurance (other than Medicaid) at the time of his/her service?	Answer yes or no. If yes, please provide the name of insurance.
Full Name	List by name, the family members in the immediate family INCLUDING yourself (applicant), applicant's spouse (living in the home or not), applicant's children under 18* (natural or adoptive) who live in the same home as the patient, and any person lving in the home with the patient who is dependent on the patient's family income for over 50% of their support. *If the patient is a minor, both biological parents must be listed on the application (living in the home or not).
Birth Date	Date of birth of each of the persons in the household.
Relationship to Applicant	List how this person is related to the applicant. Example: Applicant (self), Spouse, or Child (natural or adoptive).
Source of Income	List the source of income for this person. This would include unemployment, Social Security, VA, pensions, etc.
Income for three (3) months PRIOR to date of Service	Enter amount of GROSS income each person received within the 90 days before the service date. If there was no income received within 90 days prior, enter 0. Example: Date of service 4/1/22 – how much income was received 1/1/22 thru 3/31/22.
Income for twelve (12) months PRIOR to date of Service	Enter amount of GROSS income each person received within the 12 months before the service date. If there was no income received within 12 months prior, enter 0. Example: Date of service 4/1/22 –how much income was received 4/1/21 thru 3/31/22.
If you report $0.00 or minimal income, provide an explanation of how you were being supported	Explain your means of support for the 3 and 12 months prior to the service date. If you received support from another person, please explain stating the time period they have supported you and the type of support they have provided (ex. food, shelter, etc.).
Income Check Boxes	Check all boxes that apply and provide supporting documentation for each.
Liquid Assets Check Boxes	Check all boxes that apply and provide supporting documentation for each.
Applicant's Signature	Sign and date the application.

Please attach copies of income verification for the 3 and 12 months PRIOR to the service date. (Do not send originals as they cannot be returned)

Failure to provide information requested on this form may result in significant processing delays and/or the denial of your application.

Call our Avita PFS Customer Service Line with questions or to request assistance completing the application: 419-468-0512