



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 <small>(e.g. Employment, SSI, Child Support, Alimony)</small>	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 ***

- | | |
|-----------------------------|------------------------------|
| Wages | Child Support or Alimony |
| Social Security | Food Stamps |
| Veterans Benefits | Unemployment Compensation |
| SSI - Disability | Rental Income |
| Railroad Benefits | Dividends/Interest/Royalties |
| Self-Employment Income | Military Family Allotments |
| Retirement/Pension Benefits | Estates/Trusts |

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

- 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: Financial Counselor, Avita Health System, 269 Portland Way South, Galion, OH 44833
 Call our Customer Service Line with questions or to request assistance completing the application: **419-468-0512**