Holzer

100 Jackson Pike Gallipolis, OH 45631

Financial Assistance Application

Dates of Hospital Services | *From* _____ *to* _____

Patient Name _____ Application Date _____

Patient's Birth Date_____ Phone Number(s) _____

Street Address _____ Apartment Number _____

Mailing Address *(if different than above)* _____ City_____

State _____ Zip Code _____ Email Address _____

Patient Employer/Income Source _____
Dates Employed _____ to _____ (*If unemployed or reporting no income in last 3 years, complete Zero Income Affidavit below)*

Spouse Employer/Income Source _____
Dates Employed _____ to _____ (*If unemployed or reporting no income in last 3 years, complete Zero Income Affidavit below)*

Were you a resident of Ohio during the date(s) of service? Yes No
Do you receive Medicaid or Disability Assistance? Yes No
Did you have Health Insurance during the date(s) of service? Yes No

Household Information and Income of all persons within household

Gross Income includes pre-tax wages including but not limited to: rental income, unemployment, social security or other public assistance benefits, alimony, pension, retirement, seasonal and/or temporary work wages. Child Support and Parental Income is required for patients under 18 years of age. A minimum of 3 months income records is required, in weekly, bi-weekly and monthly amounts. Self Employed Income must include appropriate tax documentation and 1 year's monthly expenses.

Name of Household Member	Age	Relationship to Patient	Gross Income at Date of Service				Gross Income at Time of Signature			
			Weekly	*Bi-Weekly*	*Monthly*	*Yearly*	*Weekly*	*Bi-Weekly*	*Monthly*	*Yearly*
		Self								

Zero Income Affidavit

If the patient and/or spouse claims Zero Income during any timeframe within last 12 months from date of service(s), complete the following.

I attest that I had no income during date(s) _____ to _____. I am supporting myself and/or household members through the following means _____.

My signature certifies all information provided on this application and/or any attachment(s) provided is true.

_____ _____ _____ _____
Signature of Patient for Zero Affidavit Date Signature of Spouse for Zero Affidavit Date

By my signature below, I confirm the information provided on this application including my financial information provided to Holzer Health System is accurate and true. I understand by filling out this application for Financial Assistance I am not guaranteed receipt of financial assistance and I am responsible for rendering payment for services and goods received.

_____ _____ _____ _____
Signature of Patient/Guardian Date Signature of Holzer Financial Representative Date