Cincinnati Children's
changing the outcome together

Please return to:
Cincinnati Children's Hospital
Billing Customer Service
3333 Burnet Avenue, MLC 5011
Cincinnati, Ohio 45229-3026
Fax: 513-803-6577

Balance after Insurance/Financial Assistance/Self-Pay Application Form

PLEASE PRINT _____

Today's Date: _____ PFC _____FT_____
MONTH DAY YEAR (office use only)

Responsible Party: _____
LAST FIRST M.I.

Patient Name: _____
(One application per patient is required) LAST FIRST M.I.

Patient Address **at time of medical care**: _____
STREET APT. NO

_____ _____ _____ _____
CITY STATE ZIP CODE COUNTY

Current Address_____
STREET APT. NO.

_____ _____ _____ _____
CITY STATE ZIP CODE COUNTY

Date of Hospital Services: _____ Patient Birth Date: _____
MONTH DAY YEAR MONTH DAY YEAR

Did the patient have health insurance or Medicaid at the time of the hospital service? Yes ☐ No ☐
If you answered "Yes", please attach a copy of the insurance card (front and back) or Medicaid card that covers the patient and complete the following:

Name of Insurance(s) Company and/or Medicaid Program: _____

Insurance Subscriber ID# (s) or Medicaid ID Number: _____

Please note:

- Discounts do not apply to professional services rendered by a non-CCHMC employed provider and **do not cover copayments.**
- Families who are members of an insurance plan that is **not contracted** with Cincinnati Children's Hospital Medical Center will not be eligible for the discount on the unpaid portion of their claim. You will only be eligible for discounts on the balance attributed to deductibles and/or co-insurance.
- Financial Assistance is a source of last resort and other applicable insurance(s) should be exhausted prior to the discount being applied.

Please complete the following: *If the patient is 18 years of age, or older, the patient must complete this application.*
Please list all household members below. Include the patient, the patient's parents (regardless if they live in the home) & children (natural or adoptive) under the age of 18 living in the home along with the patient. If you need more space, list any additional family members in the Support Statement box on the next page that live in the household.

FAMILY MEMBERS	AGE **AND** DOB	**RELATIONSHIP TO PATIENT** (NOTE IF ABSENT PARENT)
1.		
2.		
3.		
4.		
5.		
6.		

Please complete and sign page 2 of this application.

List **ALL** household income below including gross (pretax) wages, social security benefits, child support, rental income, unemployment, etc. Other examples of Income are listed below. ***If there is an absent parent, not living in the household, list income or child support you are receiving from the absent parent***. List any additional income in the Support Statement box below. Verifications of Income and Residency is required.

FAMILY MEMBER	SOURCE OF INCOME OR EMPLOYER NAME	INCOME FOR 3 AND/OR 12 MONTHS **PRIOR TO** THE DATE OF SERVICE

In **addition to the completed financial assistance application we also need the following documentation:**

1. **Proof of all gross (pretax) income.** Attach earned or unearned income that reflects income 3 or 12 months prior to the hospital date of service. **Examples of income may include but not limited to**: Pay Stubs that reflect your year to date gross income prior to the date of service, W-2(s), Child Support (only if the patient is the intended recipient), Letter from Employer (if stubs are unobtainable), Award Letters, Unemployment, Social Security Income Statement (before deductions), VA Benefits, Alimony, Cash Receipts, Rental Income, Pension/Retirement Income or other income not listed**. If you are reporting $0.00 income,** please complete the Support Statement, below, explaining how you and/or your family were being supported at the time medical care was provided**. If you are claiming Self-Employed,** write an attestation of your income, sign and date, and provide a copy of your Schedule C, along with a copy of page 1 of your Federal Tax Return.

2. **Proof of Residency**. Include a copy of **one** of the following acceptable documents that displays your **address during the time that medical care was received**: utility bill, phone or cable bill, a rent receipt, a credit card bill, your voter registration card or a copy of your driver's license or state identification card.

By my signature below, I certify that I have carefully read this application and that everything I have stated or any documentation I have attached is true and correct to the best of my knowledge and belief. **I understand that it is unlawful to knowingly submit false information to obtain financial assistance.**

Responsible Party Signature_____ Date Completed_____

If you have any questions, please contact the Billing Customer Service Department of Cincinnati Children's Hospital Medical Center, 3333 Burnet Avenue, MLC 5011, Cincinnati, Ohio 45229-3026 or by calling 513-636-4427 option 9 or 1-800-344-2462, ext. 4427. E-mail Questions to PFC@cchmc.org Office hours are 7:30 a.m. to 5:00 p.m. Monday – Friday. Our fax number is 513-803-6577.

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If you are reporting $0.00 income, please complete the Support Statement explaining how you and/or your family were being supported at the time medical care was provided**.**

SUPPORT STATEMENT