The Bellevue Hospital
EST. 1917
Quality Care, Close To Home

Financial Assistance Application Form

PATIENT NAME: ______________________________ **DATE:** ______________

APPLICANT NAME, IF NOT PATIENT: ______________________________

(If applicant is not the patient, answer the following questions as they apply to the patient)

PATIENT BIRTH DATE: ______________ **STREET ADDRESS:** ______________________

CITY, STATE, ZIP CODE: ______________________ **PHONE:** ______________

	From	To	Visit #/ Hospital Ref #	$ Dollar Amount			
Date of Service:	________	________	________		**Inpatient**	**Outpatient**	**ER**

(An 'eligible' service date includes out-patient services for 90 days immediately following the first approved day.)

Did you have health insurance at the time of your hospital service? Yes ___ No ___

Were you an active recipient of Ohio Disability Assistance at the time of your hospital service? Yes ___ No ___
(If you answered Yes to this question, please attach a copy of your DA card effective for above date of service)

Were you an active Medicaid recipient at the time of your hospital service? Yes ___ No ___
If yes, Medicaid recipient ID number: ______________________

Were you an Ohio resident at the time of your hospital service? Yes ___ No ___

Immediate family defined as patient, patient's spouse and all the patient's children under 18 (natural & adoptive) who live in the patient's home. If the patient is under age 18, the family shall include the patient, the patient's natural or adoptive parent(s) and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Family Member Name	Age	Relationship to Patient	GROSS Income for 3-month period prior to date of service	GROSS Income for 12-month period prior to date of service	Type of Income
(Patient)		(Self)			
Total persons in family:		**Total Family Gross Income:**			

****If income does not support basic living needs explain how you are being supported** ______________________

Applicant must provide proof of income: paystubs showing 3 mos. and year to date gross income prior to service date, Social Security, Disability, Unemployment, Workers Comp, VA, Self-employment, Rentals, Alimony, Child Support, 401/IRA withdrawls, etc.

Mail to : The Bellevue Hospital, PO Box 8004, Bellevue, OH 44811. Attn: Financial Counseling.

By my signature below, I certify everything I have stated on this application and on attachments is true.

______________________________ ______________

Applicant Signature **Date**

Hospital Use Only

Approved____Denied_____HCAP ____BCA ___@_____% adjustment Denial Reason ______________________

Financial Counselor ______________________ Date ________ Reviewed By ______________________

REV 10/1/2024