PROMEDICA

Financial Assistance Application

Directions for completing application
Please complete all of the fields on this application **and sign** the application where indicated. Please provide all types of gross family income as indicated below. Proof of your income should also be provided. Types of proof include wage verification (pay stubs 1 year prior to the date of service you are requesting assistance for), unemployment information, Social Security award letters, self-employment records, disability or worker's compensation, alimony, child support, pensions, income tax returns (if self-employed), etc. If you have questions, please contact us at 844-373-0871.

Please note all information provided is confidential and is only used for the purpose of determining your discount.

If your family income after January 16, 2025 is within the income ranges below, you may be eligible to receive free care for necessary medical services even if you have insurance.

Family Size	Annual Income
1	$31,300
2	$42,300
3	$53,300
4	$64,300
5	$75,300
6	$86,300
7	$97,300
8	$108,300
For each additional person add:	$11,000

If you do not have insurance and your family income after January 16, 2025 is within the ranges below, you may be eligible for **discounted care**.

Family Size	Annual Income
1	$93,900
2	$126,900
3	$159,900
4	$192,900
5	$225,900
6	$258,900
7	$291,900
8	$324,900
For each additional person add:	$33,000

Today's Date: _____ Visit/Account # _____

Patient Name: _____ _____ Last 4 Digits of Patient Social Security # _____

Patient address: _____

Home Phone # _____ Cell Phone # _____

City: _____ State: _____ Zip code: _____

Please provide your email address if you would like to receive communication regarding this application via email:

_____

Patient date of birth: _____/_____/____ Marital Status: S M W D Gender: M F

What county do you live in? _____

Have you been a resident of that county for the past 6 months? Yes No

Are you a citizen of the United States? Yes No

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

Please provide the following information for you and all of the people in your immediate family that live in your home. For the purposes of this application, "family" is defined as the patient, patient's spouse and biological or adopted children under the age of 18 who live in the patient's home. If patient is under 18, please include parent's income. ***Please enter income numbers only; leaving blank fields, entering N/A or dashes will be an automatic denial.***

Name	Age	Relationship to Patient	Gross Income 3 Months Prior to Date of Service	Gross Income 12 Months Prior to Date of Service	Current Gross Monthly Income	Type of Income
		SELF				
Total persons in family:		Total Family Income:				

If there is **no income**, please explain how patient is supporting self: _____

Patient/Guarantor employer for the last 12 months:

Name of employer: _____ Date hired: _____ Date Ended: _____
Name of employer: _____ Date hired: _____ Date Ended: _____

Spouse's employer for the last 12 months:

Name of employer: _____ Date hired: _____ Date Ended: _____
Name of employer: _____ Date hired: _____ Date Ended: _____

Have you applied for Medicaid? Yes No If yes, what were the results? _____
If no, you were denied by Medicaid why? _____
Have you applied for Social Security disability assistance? Yes No
If yes, what were the results? Approved Denied If approved effective date: _____
Do you have health insurance other than Medicaid? Yes No
How much do you have in your checking, savings accounts, 401k, IRA, etc.?_____. In the chart below please provide any expenses you may have.
*Please provide a copy of your bank statements

Housing:	Car:	Electric/Gas:	Medical:
Food:	Other:		

Do you have auto insurance if service is auto related? Yes No
If yes, please list information below:
Name of Insurance: _____ Policy # _____ Group# ____
Address of Insurance: _____ Phone # _____

I understand any financial assistance provided may be reversed if it is determined this information is not correct. "Providing false information to induce another to extend credit or to bestow any other valuable benefit may be a violation of the Ohio Revised Code Section 2921.13."

By signing below, I state the information on this application is true to the best of my knowledge.

_____ _____
Signature of patient/guarantor **Date/Time**

_____ _____
Signature of spouse **Date/Time**

_____ _____
Signature of staff member (if applicable) **Date/Time**

If you have questions, please contact us at 844-373-0871.
Mail the completed application to: MSC-J38968 ProMedica Financial Assistance 300 North Summit Street Toledo, Ohio 43604.
Or Email to: financial.assist@promedica.org