Premier Health Hospitals
Care Assurance / Financial Assistance Program

Atrium Medical Center
Miami Valley Hospital
Upper Valley Medical Center

Hospital Account Number:

Patient Name	
Applicant Name (If the applicant is not the Patient, please answer the following questions as they apply to the Patient)	
Birth Date	**Telephone Number**
Date of Hospital Service	
1) Was the patient a resident of Ohio at the time of service? ☐ Yes or ☐ No	
2) Did the patient have Medical Insurance at the time of service? ☐ Yes or ☐ No ***If yes***, attach copy of insurance medical card.	
3) Was patient an active Medicaid recipient at time of service? ☐ Yes or ☐ No ***If yes***, attach copy of insurance medical card.	

The following information must be provided for all people in your "Immediate family who live in your home. For purposes of HCAP, "Immediate Family" is defined as the parent(s), Patient's spouse (regardless of whether they live in the home), and all of the Patient's children under 18 (natural or adoptive) who live in the Patient's home. If the patient is a minor both biological parents must be listed – even if they do not live together.

Full Name	Age	Relation to Patient	Gross Income for *3* calendar months prior to hospital service	Gross Income for *12* calendar months prior to hospital service	**Source of Income** (examples employment, pension, SSI) and **Type of Asset** (examples 2nd home, multiple cars, IRA)
		Self			
Total persons in family:		Total family income:			

If you reported **$0 income**, please provide a brief explanation of how you (or the Patient) are meeting daily needs:	**Proof of Income and Assets, if applicable, must be provided to complete processing of this application.**	**Please check type of income & asset verification attached:** ☐ Copies of Pay Stubs for 3 and/or 12 months prior to date of service ☐ Letter from Employer(s) stating gross income for 3 and/or 12 months prior to date of service ☐ Income Tax Return(s) ☐ Social Security Letter(s) ☐ All W-2's for the household ☐ Other (Deed. Car Registration)

By signing below, I certify that the above and attached information is correct and complete to the best of my knowledge. I understand that falsification of any information provided may cause rejection of my application and full reinstatement of total account balances due to the above hospital.

(Required) Signature of Patient / Responsible Party: _____ **Date**: _____
(If patient is under the age of 18, it must be signed by a parent or legal guardian)

**If the patient is unable to sign, applicant must provide written explanation as to why:

_____

Signature of Hospital Representative: _____ **Date:** _____

Return this form with income verification to:
PHP-Care Assurance/FAP Program
PO Box 932715
Cleveland, OH 44193

For any questions on how to complete this form, call Customer Service at (937) 499-7364.