COLEMAN HEALTH SERVICES FINANCIAL ASSISTANCE APPLICATION

If you believe you may qualify for financial assistance, complete this application. The entire application, including signature must be completed and signed to be considered.

For questions or concerns related to completion of this application, please contact a CPS Financial Counselor.

Client Name: _____ Client Date of Birth: _____ Date of Service: _____

Address: _____ Marital Status: _____ Account #: _____

City: _____ Phone No: _____ Facility Received: _____

State: _____ Zip Code: _____

Were you an Ohio resident on this date of service? o Yes o No

Do you currently have health insurances? o Yes o No *If yes, enter information below & attach copy of insurance card*

Name of Insurance Company:_____ Policy # _____ Group #: _____

Do you have a Medicaid benefit? o Yes o No If yes, enter billing #_____ & attach copy of Medicaid card

If no, what is the date of last denial? _____

Please list all household members below. Include parents, spouses (regardless if they live in the home) & children (natural or adoptive) under the age of 18 living in the home along with the patient. Include copies of income verifications such as pay stubs, social security determinations, workers compensation, tax returns, or call a CPS Financial Counselor to discuss other evidence that may be provided to demonstrate eligibility.

Client Family Members	Age	Relationship to Client	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service
Client -		self			
2.					
3.					
4.					
5.					

If you reported $0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested above.

I also have bills from the following CPS locations: ☐ JEFFERSON ☐ AAH ☐ MAHONING ☐ PORTAGE ☐ STARK ☐ SUMMIT ☐ TRUMBULL

By my signature below, I attest to the best of my knowledge and belief that the answers on this application are true. I understand that it is unlawful to knowingly submit false information to obtain government benefits. I further understand that other parties may rely on the information I provide herein. I hereby authorize them to do so.

Responsible Party Signature: X _____ Date:_____

CPS Representative Signature: X _____ Date:_____

FOR OFFICE USE ONLY: **Medical Record No: _____ Date Completed: _____**

Income Override Request

Reason for Request (Please mark all that apply):

❑ *DLA Score* ________ ❑ *High Risk* ❑ *Non-Covered Services* ❑ *Other (please detail)* ____

- -

Responsible Party Signature: X ____**Date:**______________________________

CPS Representative Signature: X ____ ____**Date:**______________________________

FOR OFFICE USE ONLY: **Sliding Scale** __________ **o NOT QUALIFIED** **Date Completed:** _________________________