Financial Assistance Application Information for TriHealth Patients

iHealth

All Ohio hospitals are required to provide medically necessary care, without charge, to eligible persons. To be eligible, an individual must:

1. Be a resident of Ohio
2. Not be currently receiving Medicaid benefits
3. Be a person whose income or whose family's income is at or below the Federal Income Poverty Guidelines.

Even if you are not eligible for free care through the State of Ohio program, you may still be eligible for a discount on hospital services through the TriHealth Financial Assistance Program. You may qualify for this program if your income is at or below 400% of the Federal Poverty Guidelines even if you are not a resident of Ohio.

Family Size	Federal Income 2016 Poverty Guidelines	TriHealth Financial Assistance 2016 Income Guidelines
1	$11,880	$35,640
2	$16,020	$48,060
3	$20,160	$60,480
4	$24,300	$72,900
5	$28,440	$85,320
6	$32,580	$97,740

Account #: _____

If you wish to apply, please complete the family size/income section below. All spaces must be completed for application to be accepted.

Patient/Guarantor Info: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Have you applied for Medicaid? ◯ Yes ◯ No

Do you have health insurance? ◯ Yes ◯ No Are you on active disability? ◯ Yes ◯ No

If you have health insurance, please attach copy of insurance card to application.

In order to process your application, you must attest to your total gross household income for the 3 or 12 months prior to the date of service for the following types of income. Please indicate if the income is for 3 or 12 months.

Wages, Bonuses, Tips	Farm or Self Employment	Pensions	Public Assistance
Social Security	Workers' Compensation	Strike Benefits	Unemployment Compensation
Alimony, Child Support	Military Allotments	401K/403B	Interest, Dividends, Rents

You may be asked to provide documentation to support the income information attested to below. Please give the following information for the patient, spouse (married or separated) and all of the patient's children (natural or adopted) under the age of 18, living in the home. (Please list your children's names and date of birth).

First Name, Last Name	Date of Birth	Relationship to You (Self, Spouse, Child)	Social Security Number	Source of Income	Income **Prior** to Date of Service (Circle Date Span) 3 Calendar Months or 12 Calendar Months

If you list your income as $0, please provide information regarding your living situation/means of support on the lines below.

_____

_____

This document is legal and binding. Your signature below attests that, to your knowledge, the information provided is accurate.

Signature: _____ Date: _____ Must be signed and dated to be valid.

Mail completed application to: Financial Assistance, TriHealth Inc., 619 Oak Street, Cincinnati, OH 45206-9975