GENESIS HEALTHCARE SYSTEM-FINANCIAL ASSISTANCE APPLICATION

Applicant Name	**Marital Status**: Single Married Divorced Separated Widowed
Applicant Address	**Daytime Phone Contact**
Patient Name(s)	

SECTION I-QUALIFIED HOUSEHOLD DEPENDENTS *(Definition: Self, Spouse, BIOLOGICAL or LEGALLY ADOPTED Children under the age of 18 that reside in household)*

Name	Age	Relationship to Patient	3 Month Income	12 Month Income
		Self		
		Spouse		
		Child		
Total Household Dependents		**Gross Household Income**		

SECTION II-GENERAL QUESTIONS-CIRCLE YES OR NO RESPONSE AND PROVIDE DETAIL AS REQUESTED

Is the patient a United States Citizen? **Yes** **No**

Was the patient an OHIO resident at the time of the hospital service? **Yes** **No**

Does the Patient have Medicaid? If Yes, provide Medicaid #____________________ **Yes** **No**

Does the patient have insurance? **Yes** **No**
If **Yes**, provide name of primary insurance: ____

Does the patient have any other supplemental income? Circle any or all of the following if appropriate: **Yes** **No**

College overages/grants Child Support (If child is the patient) Cash Assistance from legally separated spouse Health Savings Account

If **yes**, confirm amount received & date(s)________________________________ Health Savings Account Balance:________________________________

Is the patient willing to apply for Medicaid? **Yes** **No**

"No" -I have elected to **not** apply for Ohio Medicaid. I am aware that this will make me ineligible for 100% assistance based on the Federal Poverty Guidelines. The maximum amount that I can be awarded is 75%.

Do you have assets in excess of $5000.00? (If **yes,** see below). **Yes** **No**

Assets	Value		Asset Calculation Value	Annual Excess Asset Responsibility %
Checking/Savings Account(s)		***Hospital Use Only:***	Under $5000	0%
CD's, Money Market(s), Stocks/Bonds			$5001.00 - $15,000.00	2.5%
Property - Exclude Primary Residence			$15001.00 +	5%
Other (Specify)		Total Asset Value for year__________ - $5000.00 = __________(Asset Base)		**Percentage:**
Total Assets		Annual Excess Asset Due:		

SECTION III-GROSS HOUSEHOLD INCOME

1. *Income Verification: Pay stubs* *(3 months prior to date of service OR application date),* ***Social Security letter, etc.*** *(We* ***cannot*** *accept W2's or Bank Statements).*
Ex. Date of Service is 9/1/17 requires pay check dates from June, July, & August). OR Ex. Application date is 8/1/17 requires pay check dates May, June, & July).

2. *Zero Income:* (SEE BELOW) Must provide written statement (IVS)
Zero income Statement (IVS)
I, ____________________________(patient/applicant name), have had no income from ______________*(date)* through _______________ *(date)* prior to date of service. I did not receive Social Security, Bureau of Worker's Compensation or Unemployment income during this time.
Complete statement identifying source that provided shelter and basic needs:____

3. *Self Employed* : Previous year's completed income tax return, **Including Schedules** AND Complete IVS below:
Self -Employed Income Statement (IVS)
I, ____________________________(patient/guarantor name), verify that the gross household income from ______________(date) through _______________ (date) is comparable to earnings reported on the attached Income Tax Return for ___________(year).

REMINDER: Complete ALL required Sections. Incomplete applications will be returned for additional information.

SUBMITTING APPLICATION FOR PROCESSING *- Email: applications@genesishcs.org (Please be sure to attach related documents).*
Walk-in or Mail: Genesis Healthcare System 2800 Maple Avenue Suite 170P Zanesville Ohio 43701 Attn: Patient Resource Center

Affirmation

I understand that the gross household information which I have provided may be available for review by federal and/or state enforcement agencies and is subject to verification by Genesis Healthcare System. I hereby authorize Genesis Healthcare System to do a credit check, if necessary, to determine my eligibility for financial assistance. If the information is determined to be false, I understand that I will be liable for all charges related to services included in this application. Should any changes occur in the information provided, I agree to promptly notify Genesis Healthcare System.

Applicant Signature (Required)	**Date Signed**
Spouse's Signature (Required)	**Date Signed**