GENESIS HEALTHCARE SYSTEM-FINANCIAL ASSISTANCE APPLICATION

Applicant Name	**Marital Status**: Single Married Divorced Separated Widowed
Applicant Address (Street Address, City, State, Zip Code)	**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	**Date of Birth**	**Relationship to Patient**	**3 Month Income**	**12 Month Income**
		Self		
		Spouse		
		Child		
			Please circle the following entities you have outstanding balances with:	
			Genesis Healthcare System	Genesis Medical Group
Total Household Dependents		**Gross Household Income**	Genesis Primary Care	

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**

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%.

SECTION III-GROSS HOUSEHOLD INCOME

1. Income Verification:Pay stubs *(3 months prior to month of service OR application date),* ***Social Security letter, etc.*** *(We* ***cannot*** *accept W2's or Bank Statements).* ***Ex. Date of Service is 9/1/24 requires pay check dates from June, July, & August). OR Ex. Application date is 8/1/24 requires pay check dates May, June, & July).***

2. ***Zero Income:*** 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).

3. ***Self Employed*** **: Will be required to present the past 3 months of books and 1 of either Tax Return with Schedules, or Pay Stubs.**

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 FAX: 740-571-0028

Affirmation

I certify that (i) the information in this application is true and correct to the best of my knowledge; and (ii) I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. If the information is determined to be false, I understand that any financial assistance granted to me will be reversed and 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 (the "Hospital").

I understand that the information provided in this application may be verified by the Hospital and be available for review by federal and/or state enforcement agencies. *I hereby authorize the Hospital or agent(s) acting on Hospital's behalf to contact third parties to verify the accuracy of the information provided in this application* and release Hospital, such agent(s), and any third party verifying such information from liability for any acts, communications or disclosures which are made pursuant to such verification. I hereby authorize Genesis Healthcare System to do a credit check, if necessary, to determine my eligibility for financial assistance.

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