AULTMAN and AULTMAN ORRVILLE

☐ **Hospital** ☐ **Physician** **INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED** **Account #** _____

PATIENT NAME: _____ Date of Birth: _____/_____/_____
SSN (optional): _____

APPLICANT NAME (if not a patient): _____
(If the applicant is not the patient, please answer the following questions as they apply to the patient.)

STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE NUMBER: _____

The following questions must be answered in order to process your application:

1. Were you an Ohio resident at the time of your hospital service? ☐ Yes ☐ No
2. Did you have health insurance other than Medicaid at the time of your service? ☐ Yes ☐ No
3. Were you an active Medicaid/DMA recipient at the time of your service? ☐ Yes ☐ No
   If yes, Medicaid recipient ID number: _____
4. Do you authorize **Aultman Hospital Patient Outreach** and **Aultman Orrville Hospital** to act on your behalf to qualify you for the greatest amount of assistance? (To determine eligibility, an Aultman/Aultman Orrville representative may contact you for additional information. You may also be contacted by a third-party organization to verify your Medicaid application or notify you of meetings and documents that are required to complete the Medicaid process). ☐ Yes ☐ No
5. ☐ Single ☐ Married ☐ Separated (if separated, spouse's income is still required).
6. Are you Amish? ☐ Yes ☐ No
7. Do you have assets such as 401K, CD's or investments? ☐ Yes ☐ No

OFFICE USE ONLY
State of Ohio HCAP Approved
❑ **YES** ❑ **NO**
Aultman FAP Approved
❑ **YES** ❑ **NO**
FAP Discount _____%
HCAP/FAP Eligibility Dates
From: _____
To: _____
Aultman MSO Approved
❑ **YES** ❑ **NO**

☐ Check if you are self-employed and include your 1040 and appropriate schedule.

Please provide the following information for family members living in the home. Family members include you, your spouse, and/or natural or adopted children under age 18. For patients under the age of 18, list the patient, the patient's natural or adoptive parent(s) (regardless of whether or not the parent lives in the home with the patient) and the patient's siblings (natural or adoptive) who live in the home.

Name (First, Last)	Age	Relationship to Patient	Regular Wages, Pensions, Social Security, SSI, V A Benefits	How Often weekly/ every 2 weeks/ monthly	Type of Income	Total Gross Income* for 3 months prior to service date *Prior to Deductions	Total Gross Income* for 12 months prior to service date *Prior to Deductions	Please list 401K, CD's or investments
Jane Doe (example)	43	Self	$200.00	Weekly	Unemployment	$2,400.00	$9,600.00	
(Patient)								
Total Family Size:					Total Income:			

NOTE: If you or any family members have no income, you must state "0".

If you reported zero "0" income, please explain below how basic food and housing needs were provided prior to the date of service:

_____

_____.

By my signature below, I affirm that to the best of my knowledge the answers on this application are true. I understand an authorized Aultman/Aultman Orrville representative may contact me for additional information or use a third-party organization to verify the financial information stated on this application.

Date: _____ **Applicant Signature:** _____

Date: _____ Patient Outreach Representative: _____