Cleveland Clinic Financial Assistance Application Form

SECTION ONE: PATIENT INFORMATION

Print your full name, your address at the time you received medical service and other information noted in this section.

Facility: ❑ Cleveland Clinic Main Campus or Family Health Center ❑ Cleveland Clinic Florida ❑ Lou Ruvo
❑ Euclid ❑ Fairview ❑ Hillcrest ❑ Lakewood ❑ Lutheran ❑ Marymount ❑ Medina ❑ South Pointe

Account Number _____ Date(s) of Service _____

Name: _____
LAST FIRST MIDDLE INITIAL

Address: _____ City _____ County: _____
NUMBER AND STREET

State of Residence: _____ Zip Code: _____ Social Security Number: ____/____/____ Date of Birth: ____/____/____

Marital Status: ❑ Single ❑ Married ❑ Divorced Home Phone No.: (_____) _____ Other Phone No.: (_____) _____

Are you a legal resident of the United States? ❑ Yes ❑ No

Did you have health insurance (other than Medicaid) at the time of your service? If yes, please provide your insurance information and a copy of your insurance card. ❑ Yes ❑ No

Name of insurance: _____ Effective date of insurance: ____/____/____

Subscriber Name: _____ Subscriber ID: _____ Group Number: _____

SECTION TWO: FAMILY INCOME

Provide income for yourself, your spouse and all other family members (if applicable.)

Monthly Income Source	Current Monthly Gross Income Amount Patient	Current Monthly Gross Income Amount Spouse/Other	Total Family Income for 3 months prior to date of service	Type of Income verification attached – proof of income is requested to process your application
Wages/Self Employment, Child support and alimony	$	$	$	Copy of most recent pay stubs or income award letters (for three previous months.)
Social Security	$	$	$	Social Security award letter
Pension, Dividends, Interest, Rental Income	$	$	$	Pension benefits letter, Dividend/Interest Statement
Unemployment, Workers' Compensation	$	$	$	Unemployment benefit letter, Workers' Compensation benefit letter

If you reported $0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs:

_____

SECTION THREE: FAMILY INFORMATION

List all family members in your household named on the most recent federal income tax return, and their date of birth.

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of HCAP, family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Name of family members, including patient Date of Birth Relationship to Patient

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

By my signing below, I certify that everything I have stated on this application and on any attachments is true.

Responsible Party Signature: x _____ Date: _____

Return your completed application to: **Revenue Cycle Management – Cleveland Clinic**
6801 Brecksville Rd., RK2-3, Independence, OH 44131-9980