Ballad Health Application for Financial Assistance

Application Date: _____ Patient's Name: _____

Social Security #: _____ DOB: _____ Guarantor #: _____

Account Number(s) _____, _____, _____, _____

Please provide all documentation listed below that applies. Sign and return to the address listed below. Documentation should include all family members in the household.

Required Documentation (*Do not send originals * Please use black ink)

- ☐ Last two years of Federal Tax Returns are required. If you did not file taxes, you must provide a 4506-T form from the IRS.
- ☐ W-2 and last 3 pay stubs.
- ☐ If you are drawing Social Security, Disability, or a Military Pension, you will need to provide the benefit letter.
- ☐ Retirement income, pension, annuity, short/long term disability, or worker's compensation.
- ☐ If you receive Food Stamps, please provide a copy of the approval letter.
- ☐ Stocks, Bonds, CD's and Mutual Funds
- ☐ If you own your home, you must provide copies of your most recent mortgage statement.
- ☐ Provide the most recent copy of your checking, savings, and Health Savings Account. Include all pages of the statements.
- ☐ Medicaid approval or denial letter.

Determining Eligibility

Ballad Health will determine financial assistance eligibility based on Federal Poverty Income Guidelines and assets.

Continued Collections During Your Application Process

Please note that collection actions on your account will be suspended during the consideration of a completed charity application. You will have 30 days from the date of the financial application to provide all supporting documentation or your account.

If you need assistance in completing this application, please visit a Ballad Health facility, or call 888-288-5174 Monday – Friday, 8:00 a.m. to 4:30 p.m.

Mailing Address:

Attn: Document Imaging
11511 Reed Hartman HWY
Blue Ash, OH 45241

Patient/Responsible Party Information (Please Print)

Patient Full Name	Date of Birth	Responsible Party (Spouse/Guardian/Guarantor)
Address (Physical Address)	Zip Code	City
Social Security No.	Home Telephone No.	Married ( ) Single ( ) Separated ( ) Divorced ( )
Homeowner ( ) Rent ( )	Monthly Payment	Approximate Value $
Employer (Name & Address) q Unemployed	Tel. #	Emp. Since / Monthly Income

Are any of the accounts listed due to a motor vehicle accident or any other personal injury? Yes ( ) No ( )
If yes, please provide the following info: Insurance Company or Attorney name;
Policy Number:_____ Insurance Company:_____ Attorney Name_____ Phone Number:_____

Spouse Information

Name:	Social Security No.		
Employer (Name and Address)	Tel. #	Emp. Since	Monthly Income

Dependents

Name	Date of Birth	Relationship	Name	Date of Birth	Relationship

Monthly Expenses	
Mortgage/Rent	$
Electric	$
Water	$
Telephone/Cell	$
Food	$
Clothing	$
Auto payment(s)	$
Child Care	$

Monthly Income	
Patient	$
Spouse	$
Social Security	$
Disability	$
Unemployment	$
Child Support	$
Alimony	$
Food Stamps	$
Worker's Compensation	$
Dividends, Interest	$
Other Income	$
Total Income	**$**

Assets	
Checking Account	$
Savings Account	$
Health Savings Account	$
Certificates of Deposit	$
Property	$
Other	$

Additional Assets	Estimated Value
Auto #1	$
Auto #2	$
Motorcycle #1	$
Motorcycle #2	$
Boat	$
Recreational Vehicle	$

Total Number in Household:	

Applicant's statement: I do hereby certify that the information on this form is correct and true to the best of my knowledge and that no information has been concealed or omitted from this application. I also understand that Ballad Health has the right to reverse its decision concerning charity discounts when discovery of information is made that indicates the patient/guardian/guarantor has the ability to pay for their services. I am giving Ballad Health permission to access my credit file and to provide my financial information to those companies contracted by Ballad Health for the purpose of determining eligibility for any programs for which I may qualify.

Patient/Guardian/Guarantor Signature _____ **Date** _____

Comments:

_____

_____

_____