Name: ____ Date: _______________________

Applicant Name (if not patient): ____

Street: ____

City: ______________________________________ State: ____________ Zip Code: ___________________

Contact Number: _________________________________ Date(s) of Service from ________ to ________

Circle One

- Were you legally married at the time of service? Yes No
- Were you a resident of Ohio at the time of service? Yes No
- Were you an active Medicaid recipient at the time of service? Yes No
- If yes, Medicaid recipient ID# _________________________________
- Were you an active recipient of Disability Assistance at the time of service? Yes No
- If yes, please attach a copy of your DA card effective during the above service dates.
- Did you have health insurance (other than Medicaid) at the time of service? Yes No

Please provide the following information for all the people in your immediate family who live in your home. For the purposes of this application, "family" is defined as the patient, patient's spouse, and all the patient's children under 18 (biological or adoptive) who live in the patient's home. If the patient is a minor child, the patient's living parents must be counted as "family" regardless of whether they live in the patient's home. Make sure to provide information for your spouse as well as yourself. If your spouse has $0 income, please make sure to document this. There is room on the back to make additional comments.

Name of Family Member(s)	Age	Relationship to Patient	Gross Income for Three Months Prior to Beginning Date of Service*	Gross Income for 12 Months Prior to Beginning Date of Service*	Type of Income Verification Attached**
Total Persons in Family:		**Total Family Income:**			

*Income verification should accompany this application for you and your spouse. If you reported $0 or very low income, provide a brief explanation on the back of this form or an attached sheet. (Explain why income is $0 and explain your means of survival.)

**Income verification for you and your spouse may include pay stubs or other documents containing income information for the appropriate time period (three or 12 months prior to dates of service).

By my signature below, I certify that everything I have stated on this application and on any attachments is true and I have no additional non-reported income.

____ ______________________________

Applicant Signature Date

If reporting $0 income, who provides the following:

Shelter: ____

Food: ____

Transportation: ____

Utilities: ____

Clothing: ____

How long have you lived like this? From ________________________ to __________________________

Additional comments regarding $0 income: ____

____

____

____

If you have disability assistance (DA), your card will be the document that lets us know you are eligible for free care. Please provide a copy. If you are not a DA recipient, you may be eligible for charity care depending on your income. Proof of income will be necessary for us to determine your eligibility. The US Department of Health and Human Services (DHHS) has releases the federal poverty income guidelines on a yearly basis. The guidelines are widely used to judge eligibility for state and federal programs that support low-income and uninsured individuals and generally go into effect on the date of publication in the Federal Register.

Please return this application to: East Liverpool Medical Group
425 W. 5th St.
East Liverpool, OH 43920