Lindner Center of HOPE | UC Health

How to apply for Financial Assistance through the Lindner Center of HOPE and Lindner Center of Hope Professional Associates

Please complete, sign and date the financial assistance application. If at any point in the application process you have a question, please call 513-536-0224 and speak to one of our Financial Counselors.

Please note that an application is not considered complete and will not be processed unless all information requested is received. Incomplete applications will automatically be denied 45 calendar days after the date of the signed application. Below is a list of acceptable documentation to accompany your financial application. Financial Assistance will not be considered for no-show fees nor balances already in collections.

- **Provide proof of household income** for the 12 month period prior to your date of service, including your most recent pay advices. Examples of acceptable documentation include:
    - Tax return – Front page and the Schedule 1 of the previous year's tax return. If you are claiming to be Self-Employed, provide signed attestation of income and most recent copy of Tax Schedule C.
    - Pay Stubs – From all employers for the current year.
    - Social Security Award letter(s) - From the previous and current year.
    - Pension – From the previous and current year.
    - Unemployment Compensation – Award letters with names and dates
    - Court Support order
    - Letter from your employer, on official employer letterhead, setting forth compensation details. Must include employer contact information.
    - Zero income – If the patient is reporting zero income for any length of time 12 months prior to the date of service, please complete the Support Statement near the end of the financial assistance application.
- **Proof of Residency** at the time of your date of service at the Lindner Center of Hope. Examples of acceptable documentation include:
    - Driver's license
    - Vehicle registration
    - Voter registration – matching address at the time of service
    - Rent receipts for rent paid within 60 days of when services are rendered.
    - Mortgage statement
    - Utility bill
    - Credit card or bank statement postmarked or date by the issued within 60 days of when services are rendered
    - Letter from lease management, mortgage company, or person providing the patient with shelter, including homeless shelters.
- **Proof of Insurance** Health Spending Account (HSA) or Health Reimbursement Account (HRA) and Flexible Spending Account (FSA).
    - Current HSA/HRA/FSA statements, if applicable.

Please return completed, signed, and dated application with supporting documentation directly to the Welcome Center or by ONE of the following:

Mail to: Lindner Center of Hope
Attn: Financial Counseling
4075 Old Western Row Road
Mason, Ohio 45040

Email to: Lcoh-financial-assistance@lindnercenter.org

FAX: 513-536-0239

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PLEASE RETURN TO THIS HOSPITAL'S FINANCIAL COUNSELOR OR MAIL TO:
4075 Old Western Row Road
Mason, Ohio 45040
513-536-HOPE (4673)
Office Hours: 8am to 6 pm M-F
LCOH-Financial-Assistance@LindnerCenter.org

Date of Service:____________________ **Account Number:**____________________

Patient Name:____

Date of Birth:____________________ **Phone:**(____)________________

Street Address*:____

City:____________________ **State:**__________ **Zip:**__________

Email:____

Marital Status:____________________ **Name of Spouse:**____________________

Applicant Name:____________________ **Relationship to Patient:**____________________

*Proof of residency is required. Please refer to the cover letter for a list of acceptable documents.

Please answer the following questions as they apply to this patient at their time of service. Please circle, yes or no. If not applicable, please circle no.

Were you an Ohio resident at the time of your hospital service? Yes No

Were you receiving Medicaid at the time of your hospital service? Yes No

If yes, Medicaid recipient ID number is:

Were you receiving Disability Assistance at the time of your hospital visit? Yes No

If yes, Disability Assistance ID number is:

Did you have any other health insurance at the time of your hospital service? Yes No

If yes, please provide a copy of your card if not already provided

If you have other health insurance, do you have a Health Savings Account or Health Reimbursement Account or similar fund designated for family Medical expenses? Yes No

If yes, please provide a copy of your most recent statement.

Please note, families who are members of an insurance plan that is not contracted with Lindner Center of HOPE will not be eligible for the discount on the unpaid portion of their claim. They will only be eligible for the discount on the balances attributed to deductibles and/or co-insurance. Also note that discounts may not apply if a Health Savings Account (HSA), Health Reimbursement Account (HRA) and Flexible Spending Account (FSA) or similar fund designated for family medical expenses has been established. Payment from either fund is due before any discount can apply.

HOUSEHOLD INFORMATION

Please provide the following for all of the people in your household. Household is defined as the patient, the patient's spouse, and all of the patient's children under 18 (biological, adoptive, or step-children). Please add additional sheets of paper if needed.

Name(s)	*Date of Birth*	*Relationship to patient*
		patient

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513-536-HOPE (4673)
Office Hours: 8am to 6 pm M-F

INCOME INFORMATION

Please provide income information for all family members including: gross (pretax wages), unemployment, social security, pension, child support, rental income or any income for all applicable members in your household. Proof is required for this application to be considered complete. Refer to the cover page for a list of acceptable documentation.

Name(s)	*Last date worked*	*Source of Income*	*Income total for 3 months before service*	*Income total for 12 months before service*
patient				

SUPPORT STATEMENT

If you reported zero income please complete the following:

I,(patient name)____, have had no income for the following dates beginning 12 months prior to my time of service: (list starting and ending dates)

____

Please explain your living situation and how you are financially supporting yourself:

____

____

____

____

____

Change in Circumstances: If you have experienced a recent change in your financial situation, you may include a written statement, detailing the change to be included with your application submission.

Please note: If any portion of the application is incomplete we will be unable to process your application. Incomplete applications will automatically be denied after 45 calendar days from the signed application.

By my signature below, I certify that everything I have stated on this application and in my attachments is true. I understand that any misrepresentation of income or financial status will result in the applicant assuming the responsibility of full payment of hospital and professional services.

Signature (patient/applicant):____Date: ____________________

Please note this applies only to services received at Lindner Center of HOPE. ***Must be signed and dated to be valid***

FOR LCOH PURPOSES ONLY:

MRN:_____________________________

DOS:_____________________________

IP Services_________________________

OP Services_________________________90 days from review:__________________