ST. VINCENT CHARITY
MEDICAL CENTER

Patient Name:_____ **Date of Service**_____ **Account Number**_____

Important: YOU MAY BE ABLE TO RECEIVE ADDITIONAL DISCOUNTS: Completing this application will help St. Vincent Charity Medical Center determine if you can receive free or discounted services or if you qualify for other programs that can help pay for your healthcare. Please return the ***signed*** application, with requested documents in the self-addressed envelope or mail to: **Financial Counselor-St. Vincent Charity Medical Center-2351 E. 22nd Street-Cleveland,OH 44115**

Please follow instructions carefully. Incomplete applications will delay your free care or additional discounts*

Call 1-800-721-6097, 216-694-4652 or 216-694-4653 with questions or for assistance

INSTRUCTIONS: COMPLETE THE APPLICATION IN FULL AND SIGN					
Last Name	First	M.I.	Date of Birth		Social Security Number - -
Street	Apt. #	City	State	Zip Code	Home Phone:
Email Address:					Cell Phone:
Do you have Medicaid Benefits? Y/N			Are you an Ohio Resident?-Y/N		

DEPENDENTS/INCOME

Please list your name, spouse's name and dependents under the age of 18. List income amounts below for all members of your household with income.

Name	Relationship	Age	Income Source	Income/1 mo.	x 12 =Total Income

Provide one or more of the following for every household member with income:

1. a copy of most recent tax return
2. a copy of most recent pay stub or a statement from your employer if paid in cash
3. a copy of most recent W-2. 1099 forms, or other income documents

You may also receive income or support from **SSA, disability, child support, alimony, unemployment, workers' compensation, veteran's pension or disability, retirement income, or other income**. Please list the source and amount of income for each household member.

****If you are claiming $0.00 income, please tell us on the lines below how you are meeting daily living expenses (for example-living with relatives/friends)****

APPLICANT CERTIFICATION: I certify that this information is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the above information. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

_____ _____

Applicant Signature Date

Office Use Only:

Authorized hospital representative:_____ Date:_____

☐ **HCAP Application** ☐ **Financial Aid Program (FAP) Application**