Summa Rehab Hospital
A partnership with Ernest Health

Summa Rehab Hospital Application for Financial Assistance
Summa Rehab Hospital Charity Program
Uninsured Patient Discount Program

Please Print All Information

PATIENT NAME (LAST, FIRST, MI)			SOCIAL SECURITY NO.	DATE OF BIRTH
STREET ADDRESS	CITY	STATE ZIP CODE		DAYTIME PHONE NUMBER
☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ *SEPARATED	Employment Status at time of service ☐ EMPLOYED ☐ RETIRED ☐ UNEMPLOYED		1. WERE YOU AN OHIO RESIDENT AT THE TIME OF YOUR HOSPITAL SERVICE?	☐ YES ☐ NO
DATE OF SERVICE	HOSPITAL ACCOUNT NO.		2. WERE YOU AN ACTIVE MEDICAID RECIPIENT AT THE TIME OF YOUR HOSPITAL SERVICE IF YES, MEDICAID BILLING NUMBER _____	☐ YES ☐ NO
APPLICATION COVERS AN INPATIENT STAY AND/OR THREE MONTHS (MONTH OF SERVICE AND THE TWO FOLLOWING MONTHS)			3. WERE YOU AN ACTIVE RECEIPIENT OF DISABILITY ASSISTANCE AT THE TIME OF YOUR HOSPITAL SERVICE	☐ YES ☐ NO
SPOUSES NAME (LAST, FIRST, MI)	Employment Status at time of service ☐ EMPLOYED ☐ RETIRED ☐ UNEMPLOYED		SOCIAL SECURITY NO.	DATE OF BIRTH

"Family" includes the patient, patient's spouse *(regardless of whether they live in the home) and all patient's children, natural or adoptive, under the age of 18 who live in the home. If patient is under the age of 18, the "family" shall include patient, patient's natural or adoptive parent(s) *(regardless of whether they live in the home) and the parents children under the age of 18 who live in the home.

FAMILY MEMBER'S NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	GROSS INCOME RECEIVED WITHIN THE THREE MONTHS BEFORE MONTH OF SERVICE	SOURCE OF INCOME OR EMPLOYER NAME
(Patient)		self		
(Spouse)				
TOTAL PERSONS IN FAMILY		**TOTAL FAMILY INCOME**		

$0 INCOME STATEMENT:

Provide brief statement of how basic food/housing needs were met within the three months before date of service

*Income of spouse or parent who does not live in the home is required unless the absent spouse or parent does not contribute to the household; use INCOME block to document "Does not contribute".

** Income verification includes but is not limited to copies of total wages before taxes, pension, SSI/SSD/Unemployment benefits, alimony, child support (If child is patient), veterans' benefits, distributions from a retirement account (IRA), 401(k), 401 (b).

If you receive Social Security or Disability Benefits, a letter of income verification or your most recent 1099 form may be submitted. A letter of verification can be obtained by calling the Social Security Administration at 1-800-772-1213.

I, undersigned, have provided the above information to be considered for financial assistance through Summa Rehab Hospital and;
To the best of my knowledge, I state this is to true and accurate information, and;
I understand that Summa Rehab Hospital reserves the right to modify or cancel this program in accordance with the rules of the Ohio Department of Jobs and Family Services (ODJFS).

X _____ _____
(ONLY **PATIENT** OR A **LEGAL REPRESENTATIVE OF PATIENT** MUST SIGN FOR APPLICATIO TO BE VALID (DATE)

_____ _____
(HOSPITAL REPRESENTATIVE SIGNATURE/DEPT, OR AGENCY (DATE)

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