North Coast Health
A faith-based charitable clinic
216.228.7878 | northcoasthealth.org
16110 Detroit Avenue | Lakewood, OH 44107

Charitable Care Application

Last Name: _____ First Name: _____

Street Address: _____ Apt#: _____

City, State: _____ Zip: _____

Date of Birth: _____ Phone #: _____

Social Security #: _____ E-mail: _____

Gender ❑ Male ❑ Female Contact Preference: ❑ Phone ❑ E-mail

Do you speak English? ❑ Yes ❑ No → What is your preferred language? _____

Insurance Status
❑ Uninsured → Have you applied for Medicaid, Affordable Care Act or obtained an exemption? ❑ Yes ❑ No
❑ Medicaid
❑ Veteran
❑ Medicare → Do you have Part D? ❑ Yes ❑ No
❑ Other (please specify): _____

Employment
❑ Full-Time
❑ Temporary
❑ Part-Time
❑ Unemployed
❑ Self-employed
❑ Contract

Marital Status
❑ Single
❑ Married
❑ Separated
❑ Divorced
❑ Widowed

Race
❑ White
❑ Black
❑ Native American
❑ Asian
❑ Pacific

Ethnicity
❑ Hispanic
❑ Non-Hispanic

US Citizen?
❑ Yes
❑ No

Family Income				
Monthly Income Source	***Patient**: Current Monthly Gross Income*	***Spouse/Other**: Current Monthly Gross Income*	***Total** Monthly Income*	*Attach income verification: Proof of income is **REQUIRED** to process application*
Wages/Self Employment	$	$	$	Copy of most recent income tax return, **or** most recent W-2(s), **or** three (3) most current pay stubs
Social Security	$	$	$	Social Security award letter
Pension, dividends, interest, rental income	$	$	$	Pension benefits letter, dividend/interest statement
Unemployment, Worker's Compensation	$	$	$	Unemployment benefit letter, worker's compensation letter
Alimony or child support	$	$	$	Copy of Court Order

❑ Check here if you have NO source of income.

Family Information- List all household members. Attach a separate sheet for additional members.			***Total Household members:*** _____
Name (include patient)	*Date of Birth*	*US Citizen?*	*Relationship to Patient*
		❑ Yes ❑ No	
		❑ Yes ❑ No	
		❑ Yes ❑ No	
		❑ Yes ❑ No	
		❑ Yes ❑ No	

❑ Check here if additional sheet is attached.

CONSENT INFORMATION

I give North Coast Health permission to:

- Check my information to make sure it is true and complete.
- Share my information with the pharmacies or pharmaceutical companies that may supply my medicine for auditing and administrative purposes.
- Share my information with referral specialists.
- Share my information with referral hospitals.

I understand that North Coast Health will only use my information to:

- Decide if I qualify for services at North Coast Health.
- Administer the services.

I understand that I may call 216-228-7878 at any time to:

- Withdraw from services at North Coast Health.
- Obtain a copy of the North Coast Health privacy statement.

I understand that:

- North Coast Health can ask for more information from me at any time.
- North Coast Health can change or stop services at any time for any reason.
- I can cancel my permission in writing to use my information for additional care and treatment.
- I am responsible for co-pays or charges incurred by me based on my calculated Federal Poverty Level.
- Most services received at the North Coast Health facility are not billed. Certain labs (including, but not limited to, pap smear, cultures, urinalysis, tox screen, etc.) taken during an office visit at North Coast Health may result in a processing fee from a lab or hospital and may incur a bill. **These bills are the sole responsibility of the patient.**
- North Coast Health is not an insurance company and does not pay bills.

I promise that:

- All the information in this application, including all copies of documents proving my income is true and complete.
- I am authorized to sign this application.
- I do not have any insurance for assistance with medications.
- I will contact North Coast Health if any of my information about insurance and/or income changes including prescription assistance.

ASSIGNMENT OF BENEFITS

I hereby assign or transfer payment benefits made to me and my behalf to North Coast Health for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

RELEASE OF INFORMATION

I hereby authorize North Coast Health to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If Medicare or Medicaid patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

Emergency Contact

Name: _____

Phone #: _____

If someone helped you with this application, and you want them to answer questions for you, please give us their name and phone number.

Helper's name: _____

Phone #: _____

SIGNATURE OF APPLICANT/PATIENT OR LEGAL GUARDIAN

By my signing below, I certify that everything I have stated on this application and on any attachments is true.

X _____ Date: _____

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Family Size:		% of Poverty:	%
Amount of Income:	$	Sliding Scale Type:	❑ Scale A ❑ Scale B
	❑ Weekly ❑ Monthly ❑ Yearly	Reason:	
		Co-pay amount:	❑ $10 ❑ $20 ❑ $30 ❑ $40 ❑ Full pay
Reviewed by (printed name):		Date Approved:	
Reviewer's signature:		Eligibility Dates:	