

A faith-based charitable clinic

Charitable Care Application

216.228.7878 | northcoasthealth.org 16110 Detroit Avenue | Lakewood, OH 44107

Last Name:		Fir	rst Name:			
Street Address:		Ap	ot#:			
City, State:			p:			
Date of Birth:			one #:			
Social Security #:		E-1	mail:			
Gene	der 🗖 Male 📮 Female	Contact Pr	reference: Phone	☐ E-mail		
Do you speak Engli	sh? □ Yes □ No → W	hat is your preferred lar	nguage?			
Insurance Status		Employment	Marital Status	Race	Ethnicity	
☐ Uninsured → Have you applied for Medicaid,		☐ Full-Time	☐ Single	☐ White	☐ Hispanic	
Affordable Care Act or obtained an		□ Temporary	■ Married	☐ Black	☐ Non-Hispanic	
exemption? Yes No		☐ Part-Time	☐ Separated	☐ Native American	n	
□ Medicaid		Unemployed	☐ Divorced	☐ Asian	US Citizen?	
■ Veteran		□ Self-employed	■ Widowed	☐ Pacific	☐ Yes	
☐ Medicare → Do you have Part D? ☐ Yes ☐ No		☐ Contract			□ No	
☐ Other (please specify):						
Family Income						
•	Patient: Current	Spouse/Other: Curre	nt	Attach income	verification: Proof of income is	
Monthly Income Source	Monthly Gross Income	Monthly Gross Income	I otal Wionthiv incom	REQUIRED to process application		
Wages/Self Employment	\$	\$	\$		ecent income tax return, or -2(s), or three (3) most current	
Social Security	\$	\$	\$	Social Security	award letter	
Pension, dividends, interest, rental income	\$	\$	\$	Pension benefi statement	ts letter, dividend/interest	
Unemployment, Worker's Compensation	\$	\$	\$	Unemploymen compensation	t benefit letter, worker's letter	
Alimony or child support \$		\$	\$	\$ Copy of Court Order		
☐ Check here if you have	NO source of income.					
Family Information- List	all household members. Att	ach a separate sheet for	additional members.	Total Household n	nembers:	
Name (include patient)		Date of Birth	US Citizen?	Relationship to Pa	Relationship to Patient	
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

☐ Check here if additional sheet is attached.

Form: 111-Charitable Care App

Revised: 6/30/2015

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:

X

- 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

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

For Office Use Only			
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:	

Date:

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