FINANCIAL ASSISTANCE QUESTIONNAIRE

Thank you for choosing Madison Health for your healthcare needs. If you are in need of financial assistance, please complete this form and return to — Madison Health Heidi Beathard 210 N Main St. London, OH 43140 or call 740-845-7033.

Patient Name: _____ Account No.: _____

Social Security Number: _____ Date of Birth: _____/_____/_____

Phone Number: (____) _____ County of Residence: _____

Do you currently have Health Insurance? Y N Auto Insurance? Y N

If yes, complete the following. (Indicate Auto insurance only if visit due to automobile accident)

Name of Insurance (Health, Auto): _____

Policy or ID Number: _____ Policy Holders Name: _____

Insurance Co. Phone Number: (____) _____ Coverage Effective Date: _____/_____/_____

If no, when did you last have health insurance? _____

If coverage has terminated within the last 60 days have you been notified of COBRA? Y N

Marital Status: MARRIED SINGLE SEPARATED DIVORCED WIDOWED

Do you have any dependent children currently living in your household? Y N

If yes, how many? _____ Ages: _____

Are you currently pregnant? Y N If yes, expected due date: _____/_____/_____

Are you currently employed? Y N If no, date last worked: _____/_____/_____

Has the doctor released you to return to work? Y N Expected return date: _____/_____/_____

Do you have an illness or impairment that prevents you from working? Y N

If yes, what is this illness or impairment? _____

Are you currently receiving Social Security Disability? Y N Spouse? Y N

Is your spouse currently employed (if married)? Y N

List the current household income (per month)

	Self	Spouse
Employment income:	$ _____	$ _____
Social Security:	$ _____	$ _____
Child Support (if applicable):	$ _____	$ _____
Other:	$ _____	$ _____

Checking: $ _____ Savings: $ _____ Other Assets: $ _____

Have you recently applied for Medicaid? Y N Social Security Disability? Y N

If yes, list the County, Program, and date applied: _____

Signature: _____ Date: _____/_____/_____