OHHC
Ohio Hills Health Centers

Return Application To:
Patient Accounts Counselor
101 East Main Street
Barnesville, OH 43713
For Questions Please Call: 740-425-5087

APPLICATION FOR PATIENT DISCOUNT PROGRAM (Application must be legible or cannot be processed)

LIST BELOW ALL MEMBERS IN THE HOUSEHOLD:

Household is defined as anyone living within the same residence. Household includes but is not limited: Friends, Spouses, Boyfriends, Girlfriends, Children (natural, adoptive, step, legal ward and/or those who are considered a disabled dependent), Siblings (natural, adoptive, step, legal and/or those who are considered a disabled dependent), and/or Parents (natural, adoptive, step, or legal guardians). When there are households with shared custody of children, the children can only be listed within one household and that should be the household recognized as the financially responsible party for the children's medical bills.

NAME (Use the back for additional members)	DATE OF BIRTH	RELATIONSHIP TO HEAD OF HOUSE	Check if Receiving Income	Check for No Income

MAILING ADDRESS:	TELEPHONE NUMBER:
	Home:
	Cell:
	Alternate:

Are you in need of language translation? □ **Yes** □ **No**

HOUSEHOLD INCOME: Household income is defined as all gross income of any household members listed. You must submit hard copy proof of income verification for all household members or your application cannot be processed.

DO NOT SEND BANK STATEMENT(S) AS PROOF OF INCOME. Accepted forms of income verification: Current Tax Documentation, Self-Employment Ledger, Stipends, Child Support Payments Received, Welfare Payments, 4 Current Pay Stubs, Pension Payments, Investment Income, Proof of No Income (Income Attestation Letter), Worker's Compensation, Current W-2 and/or 1099, Unemployment Benefits Award Letter, Foreign Income, Income Award/Benefit Letter, Copy of Check received, Royalty or Lease Income, Social Security (SSI, Disability, Retirement) Statement, Capital Gains, Alimony, Veterans Benefits, Cash Support, Rental Income, Grants/Scholarships for living expenses, Income from Estates, or a Letter from Employer.

HOUSEHOLD MEMBER LISTED WITH INCOME SOURCE (Use the back for any additional income listing)	Month	Year
Please don't forget to mail in your proof of income.		

Would you like to see if you qualify for Medicaid, or the Health Insurance Marketplace? □ **Yes** □ **No**
If yes, a Certified Application Counselor will be in contact with you.

I certify that, the information on this application and all submitted documentation is correct to the best of my knowledge. I understand that it is my responsibility to report any changes in family household size and income. I understand that any false statements on this application about my household, or failure to notify Ohio Hills Health Centers of any additions or corrections to my application will jeopardize my household's eligibility for the discount and could require my household to make full payment of my household's claims.

Signature of Applicant _____ **Date** _____

OFFICE USE ONLY

_____ _____ _____
Approved By **Date** **Discount Classification**

Additional Household Members

NAME	DATE OF BIRTH	RELATIONSHIP TO HEAD OF HOUSE	Check if Receiving Income	Check for No Income

ADDITIONAL HOUSEHOLD INCOME:

Household Member listed with Income Source	Month	Year