Genesis-Bethesda
2951 Maple Avenue Zanesville,
Ohio 43701
(740) 454-4507

Genesis-Good Samaritan
800 Forest Avenue
Zanesville, Ohio 43701
(740) 454-5051

Financial Assistance Application Instruction Sheet

Please complete this application and mail it, along with the supporting documents outlined below, to the location based on your last name.

If your last name starts with the letters A through I or Q through S, mail to:

Genesis-Bethesda
Attn: Resource Counseling
2951 Maple Ave.
Zanesville, OH 43701

If your last name starts with the letters J through P or T through Z, mail to:

Genesis-Good Samaritan
Attn: Resource Counseling
800 Forest Ave.
Zanesville, OH 43701

- The definition of a "family" consists of the following:
  - The definition of a "family" shall include the patient, patient's spouse, and children, (biological or adoptive) who are under the age of 18 and reside in the home.
  - Step-parents/step-children are not included.
  - If the patient is under the age of 18, the "family" shall include the patient, the patient's biological or adoptive parent(s), and the parent(s) children, biological or adoptive, under the age of 18 who live in the home. This definition of household members claimed is set by government guidelines.

- Please provide proof of income received (3) months before the month of service. Include all check stubs received, ranging from the beginning to the end of each month. Example: date of service 1/29/2001, would need to submit proof of income from: 10/00, 11/00 and 12/00.
  - Definition of family gross income is any income received from: employment, Bureau of Worker's Compensation, unemployment, Veterans Administration, Social Security Disability, SSI, county medical programs, dividends, interest, alimony, child support, rental property income, grants received and not applied to tuition.
  - A self-employed patient must provide a copy of the most recent income tax form including schedules and the patient income verification statement (page 4 of this application).

- Sources of assistance would include: automobile insurance, Bureau of Worker's Compensation, Victims of Crime Program, county medical programs and group or private health insurance that the patient is eligible for medical coverage at the time of services.

- This assistance application is explicit to Genesis HealthCare accounts and only "hospital account numbers" listed are considered.

If you have questions about your application, please call Genesis Resource Counseling at:

Genesis-Bethesda	(740) 454-4507
Genesis-Good Samaritan	(740) 454-5051
Toll-free	1-866-522-0422, ext. 4507 or 5051
E-mail	ptaccts@genesishcs.org

Our hours are Monday through Friday, 7:30 a.m. to 5 p.m

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GENESIS HEALTHCARE SYSTEM
FINANCIAL ASSISTANCE APPLICATION

Patient Name ______________________________________

Applicant Name ____________________________________ Application Date _________

Patient Address ____________________________________ Admit Date _____________

City _______________________ State ______ Zip ________ Account# ______________

Patient Phone _________________________ Medical Record# ________

Name	Age	Relationship to patient	3 Months Income	12 Months Income
Total of Family Members		Family Gross Income		

Were you an Ohio resident at the time of hospital service? ☐Yes ☐No
Was the patient eligible for Disability SSI at the time of hospital service? ☐Yes ☐No
Was the patient an active Medicaid recipient at the time of hospital service? ☐Yes ☐No
If yes, Medicaid # ___________________________________
Has the patient applied to Medicaid with in the last 90 days? ☐Yes ☐No
Is there any other source of assistance and/or group or private health insurance, to help with payment of these accounts? ☐Yes ☐No
If yes, please explain ____

Is there any other source of assistance and/or group or private health insurance, to help with payment of these accounts? ☐Yes ☐No
If yes, please explain ____

If you are reporting zero income, please complete the following: ________________ (Date) through ________________ (Date) prior to date of service. I, (patient/applicant name) ____ have had no income from I did not receive Social Security, Bureau of Worker's Compensation, or Unemployment income during this time. Please explain your living situation and how you have been supporting yourself and your family during this time____

I understand that the information which I provided may be made available for review by federal and/or state enforcement agencies and is subject to verification by Genesis Healthcare System. I hereby authorize Genesis Healthcare System to do a credit check, if necessary, to determine my eligibility for financial assistance. If the information furnished is determined false, I understand that I will be liable for all charges for services included in this application. Should any changes occur in the information provided, I agree to promptly notify Genesis Healthcare System.

______________________________ ___________________

Signature of Applicant Date

Our Mission is…To provide compassionate quality health care.

For hospital use only

Approval Date

Denial Date

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GENESIS HEALTHCARE SYSTEM
FINANCIAL ASSISTANCE APPLICATION

Genesis HealthCare System account numbers covered by this application:

Account # ______________________________ W/O: ________________________ Adj. Balance: ___________________

Account # ______________________________ W/O: ________________________ Adj. Balance: ___________________

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Account # ______________________________ W/O: ________________________ Adj. Balance: ___________________

Account # ______________________________ W/O: ________________________ Adj. Balance: ___________________

Patient Name ____

Applicant Name ____

Account # ____

Medical Record # ____

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Patient Income Verification Statement

Patient Account Number(s): ___________________________ Date: ________________

In the space provided below, please indicate the following information:

- Specific to the month(s) required for the Financial Assistance Application, list the exact month(s) that you were unemployed and did not receive a form of income.
- During this period, who was helping to support you?
- Provide a detailed statement, if you did not receive income from the following sources:
    - Social Security
    - Bureau of Worker's Compensation
    - Unemployment

This is a government-funded program that requires this financial information.

An example is provided below to represent the set-up process for an Income Verification Statement.

- I was unemployed and did not receive an income during January 2007, February 2007 and March 2007.
- I received support from __________________________ a family member.
- I did not receive Social Security, Bureau of Worker's Compensation or Unemployment Income.

Verification Statement: ____
____
____
____
____
____
____
____

________________________________ (Witness)

________________________________ (Patient or Guardian Signature)

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