The Christ Hospital

Patient Financial Services
2139 Auburn Ave.
Cincinnati, Ohio 45219
(513) 585-1600

Application for Financial Assistance

PLEASE PRINT

Today's Date: ☐☐ / ☐☐ / ☐☐

Patient Name: ☐ (Last) ☐ (First) ☐ (M.I.)

Responsible Party, if not Patient ☐ (Last) ☐ (First) ☐ (M.I.)

Patient Address: ☐

☐ (City) ☐ (County) ☐ (State) ☐ (Zip Code)

Home Phone #: ☐☐☐ - ☐☐ - ☐☐☐☐

Home Phone #: ☐☐☐ - ☐☐ - ☐☐☐☐

Patient Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

Patient Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

Date of Hospital Services: ☐☐ / ☐☐ / ☐☐☐☐

Were you an Ohio resident at the time of your hospital services? Yes ☐ No ☐

Did you have health insurance at the time of your hospital services? Yes ☐ No ☐

Were you an active recipient of Disability Assistance or Medicaid at the time of Yes ☐ No ☐

*** If you answered "Yes" to any question, please attach a copy of your insurance card (front and back?, Medicaid, or Disability Assistance card to this application and complete the following:**

Name of Insurance Company ☐

Policy # ☐ **Group #**

Insurance Phone # ☐ **Medicaid or Disability Assistance Number** ☐