Cleveland Clinic
Union Hospital

Hospital Care Assurance Application

SECTION ONE: PATIENT INFORMATION

Print your full name, your address at the time you received medical service and other information noted in this section.

Account Number _____ Month of Service _____

Patient Name: _____
LAST FIRST MIDDLE INITIAL MEDICAL RECORD NUMBER

Address: _____
NUMBER AND STREET CITY COUNTY

State of Residence:_____ Zip Code:_____ Date of Birth:____/____/____ Patient's Social Security #: _____

Primary Phone Number: (_____)_____ ☐ Home ☐ Mobile ☐ Work ☐ Other _____

Family Member Interviewed:_____ Responsible Party:_____ Relation to Patient: _____

Are you a resident of Ohio? ☐ Yes ☐ No

Did you have Medicaid benefits? ☐ Yes ☐ No If yes, enter billing # _____ & attach copy of Medicaid card.

Do you have health insurance? ☐ Yes ☐ No If yes, enter billing # _____ & attach copy of insurance card.

SECTION TWO: FAMILY INCOME

Please list all "family" members (including yourself). Family members include parents, spouses (regardless of whether they live in the home) & children (natural or adoptive) under the age of eighteen (18) living in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, social security benefits, public assistance, etc.

Family Members	Age	Relationship to Patient	Source of Income or Employer Name	Income from 3 months prior to the Date of Service	Income from 12 months prior to the Date of Service
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
Total					

NOTE: If any of the family members had no income during the above time periods, please mark "NONE" as the income source and place 0.00 as the income.

If you report $0.00 or no income above, please provide a brief explanation below of how you (or the patient) survived financially during the above time period.

SECTION THREE: FAMILY INFORMATION AND INCOME

I affirm that the answers on this application are true, and I understand that it is unlawful to knowingly submit false information to obtain government benefits.

Applicant Signature:_____ Date Completed: _____

A new or updated application is required for each month in which services are provided.

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