THE UNIVERSITY OF TOLEDO
PHYSICIANS

Dear Patient,

The mission of The University of Toledo Physicians, LLC (UTP) is to provide high-quality, comprehensive, cost-efficient and effective healthcare in a patient-centered environment, distinguished by national leadership in medical education and research.

Because our patients are our number one priority, UTP offers a financial assistance program, based on the federal poverty guidelines, to ensure that cost isn't a barrier to exceptional healthcare.

Attached to this packet is your application for financial assistance. Please complete the application and return to UTP Customer Service at the address listed on the application or via email at UTPCustomerService@utoledo.edu.

The completed application must include your signature and total household income, along with each family member claimed on your tax return. Please remember to include spousal income, if applicable.

To process your application, UTP requires a form of income verification.
Acceptable forms of income verification documents include:

- Copy of last three pay check stubs or proof of pension
- Copy of social security statement
- Current year tax returns
- Unemployment benefit statement (if unemployed)

In addition to income, UTP requires that you attempt to qualify for Medicaid. The Ohio Medicaid program is a valuable resource for comprehensive healthcare coverage for qualifying persons. For more information, including how to attempt to qualify, please visit https://www.medicaid.ohio.gov/ or call the consumer hotline 800-324-8680

When returning your application, you must include a copy of your notice from Medicaid.

If you need assistance with completing the application, please call our customer service department at 419-383-7197, Monday through Friday from 8:00 a.m. – 4:30 p.m.

Thank you for your cooperation.

The University of Toledo Physicians, LLC
4510 Dorr St. • Mail Stop 840 • Toledo, OH 43615
419-383-7197 • Fax 419-383-2000

FINANCIAL HARDSHIP APPLICATION

ACCOUNT NUMBER:________________________________ DATE OF APPLICATION:___________________________

PATIENT NAME:____ DATE OF BIRTH:___________________________

RESPONSIBLE PARTY; IF NOT PATIENT:____

ADDRESS:____ CITY: ____________________________ STATE: ______________

ZIP CODE: _____________________ PHONE NUMBER:____

DATE(S) OF SERVICE: FROM________________________________ TO____

- Were you an active Medicaid recipient at the time of your medical services? YES__________ NO _________

  If yes, Medicaid recipient ID number: _____________________________________

- Were you an active recipient of Disability Assistance at the time of your medical services? YES__________ NO _________

  (If YES, please attach a copy of your DA card effective during your medical services to this application)

- Did you have health insurance (other than Medicaid) at the time of your medical services? YES__________ NO _________

  If YES, please provide carrier name: ____

- Are services covered by auto insurance? YES__________ NO _________

- Is there a pending litigation on these services? YES__________ NO _________

  If YES, please provide attorney contact information (Name, phone number): ____

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of financial hardship, “family” is defined as the patient, the patient’s spouse, and all of the patient’s children under 18 (natural or adoptive) who live in the patient’s home:

NAME	AGE	RELATIONSHIP TO PATIENT	INCOME FOR 3 MONTHS PRIOR TO SERVICES*	INCOME FOR 12 MONTHS PRIOR TO SERVICES*	TYPE OF INCOME VERIFICATION ATTACHED*

I ATTEST TO THE FACT THAT I WAS UNEMPLOYED FROM________________________ TO________________________

I DO NOT HAVE INSURANCE OR ANY OTHER SOURCE OF PAYMENT TO COVER THE COST OF THE SERVICES THAT I HAVE RECEIVED AT THE UNIVERSITY OF TOLEDO PHYSICIANS. I AM ATTESTING TO THE FACT THAT MY INCOME_____________ FOR MY FAMILY SIZE OF _________. I understand that is unlawful to submit false information.**

****Income verification must include complete current year income tax returns or current year paystubs. If you are on SSI or SSD you must provide a print out from the social security office.**

FAILURE TO PROVIDE ANY OF THE ABOVE INFORMATION WILL VOID THE APPLICATION PROCESS.

If you report **$0 income** provide a brief explanation of how you have supported yourself. You will also need to provide a Social Security statement for at least 3 months prior to the date of service.

____

____ INITIAL:______________

SIGNED: ____ DATE:________________

(PATIENT/GUARANTOR SIGN HERE)

University of Toledo Physicians, LLC
4510 Dorr Street · Mail Stop 840 · Toledo, Ohio 43615-4040
(419) 383-7197 · (419) 383-2000