OHHS
Ohio Hills Health Services
Excellence in Comprehensive Health Care

Return Application To:
Community Services Director
101 East Main Street
Barnesville, OH 43713
For Questions Please Call: 740-425-5167

APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

LIST BELOW ALL MEMBERS IN THE HOUSEHOLD:

Household is defined as anyone living within the same house and includes but is not limited: Spouses, Boyfriends, Girlfriends, Children (natural, adoptive, step, or legal ward and/or those who are considered a disabled dependent), Siblings (natural, adoptive, step or legal and/or those who are considered a disabled dependent), Parents (natural, adoptive, step, or legal guardians) and/or friends. 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 an additional application if more household members need to be included)	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 member listed. You must provide income verification on all listed household members listed or your application cannot be processed.

Accepted forms of income verification:
Current Tax Documentation, Self-Employment Ledger, Stipends, Child Support Payments, Welfare Payments, 3 Current Pay Stubs, Pension Payments, Investment Income, Proof of No Income (Self-Attestation Letter), Worker's Compensation, Current W-2Forms, Unemployment Benefits Award Letter, Foreign Income, Income Award/Benefit Letter, Copy of Check received, Royalty or Lease Income, Social Security (SSI, Disability, Retirement), 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 (Include on an additional application if more space is needed for household member 's income verification	Month	Year

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 Services 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 accounts.

Signature of Applicant _____ **Date** _____

OFFICE USE ONLY

_____ _____ _____
Approved By **Date** **Slide 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