

**OSU Primary Care Network
Financial Assistance Application**



OSU Office Name: _____

PATIENT NAME: _____ SOCIAL SECURITY #: _____
Last name/First name

STREET: _____ PHONE#: _____

CITY/STATE: _____ ZIP CODE: _____

***INCOME VERIFICATION MUST ACCOMPANY THIS APPLICATION, IF YOU REPORTED \$0 INCOME, PROVIDE A BRIEF EXPLANATION ON AN ATTACHED SHEET.**

****Income verification includes tax returns, pay stubs, W-2's, or other documents containing income information for the appropriate time period (3 or 12 months prior to desired date of service).**

1. Are you an Ohio resident? Yes _____ No _____
2. Are you an active Medicaid recipient? Yes _____ No _____
 If yes, Medicaid recipient ID number: _____
3. Are you an active recipient of Disability Assistance? Yes _____ No _____
4. Do you have health insurance (other than Medicaid)? Yes _____ No _____

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of the office discount policy, "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	Average Monthly Income*	Type of income verification attached ** (Copies of current pay stubs, income tax return, W-2, etc.)
(Patient)		Self		
Total persons in family		Total family income		

SEND APPLICATION TO: OSU Primary Care Network
 Attn: Lisa S.
 700 Ackerman Rd, Ste 270
 Columbus, OH 43202

Physician Name: **SOUTH HIGH OSU DENTIST**

Please allow 5 weeks for notification of approval.

By my signature below, I certify that everything I have stated on this application and on any attachments is true.

Applicant Signature _____ Date _____

INFORMATION SHEET FOR FINANCIAL ASSISTANCE

There are options available to you in order to obtain affordable medical care if you and/or your family are unable to get Medicaid or AccessHealth Columbus. You may be eligible for an OSU Primary Care Network Discount.

Here is a table to see if you would qualify financially and how much your visits would be adjusted:

Family Size 1	Adj.	Family Size 2	Adj.	Family Size 3.	Adj.
\$0-\$9,310	100%	\$0-\$12,490	100%	\$0-\$15,670	100%
\$9,311 - \$13,965	75%	\$12,491 - \$18,735	75%	\$15,671 - \$23,505	75%
\$13,966-\$18,620	50%	\$18,736-\$24,980	50%	\$23,506-\$31,340	50%
\$18,621 -\$23,275	30%	\$24,981 -\$31,225	30%	\$31,341 -\$39,175	30%
\$23,276- above	0%	\$31,226- above	0%	\$39,176- above	0%
Family Size 4.	Adj.	Family Size 5.	Adj.	Family Size 6.	Adj.
\$0-\$18,850	100%	\$0-\$22,030	100%	\$0-\$25,210	100%
\$18,851 -\$28,275	75%	\$22,031-\$33,045	75%	\$25,211 -\$37,815	75%
\$28,276 - \$37,700	50%	\$33,046 -\$44,060	50%	\$37,816 - \$50,420	50%
\$37,701 -\$47,125	30%	\$44,061 -\$55,075	30%	\$50,421 -\$63,025	30%
\$47,126 - above	0%	\$55,076 - above	0%	\$63,026 - above	0%

Fill out the application on the back of this form, attach the required documentation and mail to:

OSU Primary Care Network
 Attn: Lisa S.
 700 Ackerman Rd, Ste 270
 Columbus, Ohio 43202

Application Checklist:

- Fill out name and social security #
- Attach proof of income
- List everyone who currently lives in your home
- Sign the application