CITY OF CLEVELAND
Mayor Justin M. Bibb

EMERGENCY MEDICAL SERVICES
FINANCIAL ASSISTANCE PROGRAM

CITY OF CLEVELAND
DEPARTMENT OF FINANCE
EMS Billing Unit
601 Lakeside Avenue, Room 127
Cleveland, Ohio 44114
Phone: 216.664.2598

Financial Assistance Application **Patient Information**	
Run Number:	
Patient Name:	Date: / /
Date of Birth: ___/___/___	Social Security #: ___/___/___
Address:	Telephone Number: _____
City : State:	Zip Code:
Number of people living in household (including yourself):	How many people living with you are under 18?
Financial Information	
Are you employed? _____Yes or ____No	
What is the primary source of your income? Please identify the amount most applicable to your source of income.	
Employment: $	Disability: $
Social Security: $	Pension:$
Public Assistance: $	Public Assistance: $
What is the secondary source of income? (Specify)	
Insurance Information	
Name of Insurance:	Insurance Id. #:
Required Documentation	

Two (2) of the following documents are needed. DO NOT SEND ORGINIAL COPIES THEY WILL NOT BE RETURNED: (Place check mark (√) on the documents that are enclosed with this application.)

____Federal income tax returns / Copies of W-2
____2 Pay Stubs Bi-Weekly Pay or 4 Pay Stubs Weekly Pay
____Proof of Income (*Bank Statements are not Acceptable*)
____Official hospital financial rating report
____Other (Please Specify) _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Patient Signature:_____ Date:____/____/____

Note: **Please allow sixty (60) days for determination of eligibility to be made.**

DO NOT WRITE IN THIS AREA FOR OFFICIAL USE ONLY FINANCIAL ASSISTANCE DETERMINATION	
____Approved____Denied	Eligible for Plan A, B, C, D, E, or F
Effective Date: ____/___/_____	Expiration Date: ____/___/____
Approved By:	Signature:
Final Approval:	Date of Final Approval:____/____/____