Tri-State Pulmonary Associates
2123 Auburn Ave
Ste 401
Cincinnati, OH 45219
513.419.1102

Dear Valued Patient,

Than you for your interest in the Tri-State Pulmonary Hardship Program. Please complete the attached application listing all members of the household and their income. The following must be included in order you process your application: Copies of proof of income (Do NOT send originals), this includes prior year tax return and your three most recent pay stubs. If you have any income other than employment such as SSI, unemployment, child support, etc. please send a copy of the award letter stating your monthly/weekly benefit amount. If you have no income please complete the attached verification letter explain how you obtain food, housing transportation, etc.

If the verification of income is not included your application will be returned with an additional request.

You may submit your application any of the following ways:

- Via Mail: Tri-State Pulmonary Associates
  Attn: FHA
  2123 Auburn Ave
  Ste. 401
  Cincinnati, OH 45219
- Via Fax: 513.241.5490 – Attn: Billing FHA
- In Person: You may drop off at any of our locations

Applications will be processed upon receipt of all requested documentation. All applications will receive notification by mail stating approval or denial in the program.

Please note that this application does not apply to bills you may be receiving from **The Christ Hospital.**

Please allow 30 days for processing.

If you have any questions, please call our billing office 513.419.1102 Monday – Friday 8AM – 4PM

Thank you,

Tri-State Pulmonary Associates

Account:_____

Tri-State Pulmonary Associates

Patient Application for Discounted Medical Services

(This application does not apply to bills from **The Christ Hospital**)

Name:_____ SSN:_____

Address:_____ Phone:_____

_____ Employer:_____

Household Members Name's	Account Number	DOB	SSN	Monthly Income
Patient				
Spouse				
Dependent				
Dependent				
Dependent				

To qualify or financial assistance, you must be at or below the federal poverty level guidelines listed below:

Number in Family	Federal Poverty Threshold	150%	200%
1	$12,490	$18,735.0	$24,980
2	$16,910	$25,365.0	$33,820
3	$21,330	$31,995.0	$42,660
4	$25,750	$38,625.0	$51,500
5	$30,170	$45,255.0	$60,340
6	$34,590	$51,885.0	$69,180
Each Additional Person add	$4,420	$6,630	$8,840
Discount Fees By	75%	65%	50%

I attest that the above information is current and accurate.

Patient Signature:_____ Date:_____

For Office Use Only – DO NOT COMPLETE BELOW THIS LINE

Approved:_____ Discount percentage patient is entitled: 50% 65% 75%

Denied:_____ Reason Denied:_____

Tri-State Pulmonary Authorizing Signature: _____ Date:_____

Received:_____

Account:_____

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Please answer the following questions below, if answering yes please provide the required documents with your application. Please provide copies of the requested documentation for all members of the household. If specific information is not included we will be unable to process your application.

Yes/No	Question	If Yes, Required Documents
	Do you file taxes	Most recent federal tax return
	Is anyone in the home employed	3 Most recent consecutive pay stubs per person
	Do you receive Social Security	Monthly Benefit Letter
	Do you receive disability	Monthly Benefit Letter
	Do you receive food stamps	Determination Letter
	Do you receive child support	Documentation of ordered amount
	Do you receive unemployment	Benefit Letter
	Do you receive retirement/pension income	Monthly Benefit letter or Bank Statement
	Are you self-employed	2 month income/expense report
	Do you have any income not mentioned	Documentation to support
	Are you claiming $0 income	Zero income verification (attached)
	Are you a nursing home resident	Monthly Statement

Please provide the following information based on average income over the last 12 months.

Monthly Family Income & Source			
	Patient	**Spouse**	**Dependents**
Monthly Salary (Gross)	$	$	$
Unemployment Benefits	$	$	$
Social Security	$	$	$
Workman's Compensation	$	$	$
Child Support	$	$	$
Alimony	$	$	$
Short/Long Term Disability	$	$	$
Retirement/Pension	$	$	$
Self-Employment	$	$	$
Other	$	$	$
Total Family Income	$		

Other information you would like to provide:_____

_____

_____

Please note documentation is required for all household members. Failure to provide necessary documentation may result in a delay in processing application or a denial.

Account:_____

Please complete this form *ONLY* if you are claiming $0 income for you and all members of your household.

I, _____, confirm:

1. My place of address is: _____
2. I am (please circle one): Single Married Divorced Separated
3. I claim the following dependents (names & DOB): _____
   _____
   _____
4. I have been unemployed since:_____
5. I currently have no income of any kind including salary and wages, interest dividends, social security, workers compensation, disability, unemployment, business, rentals & royalties, inheritance, strike benefits, alimony and payments received from the state for legal guardianship or custody.
6. I am currently obtaining food and housing through the following sources: _____
   _____
   _____
   _____
   _____

Patient Signature:_____ Date:_____