University Health Services

Application

Financial Care Assistance Program for Healthcare Services

Phone: 330.672.8251 Fax: 330.672.3711

All students who seek treatment at the DeWeese Health Center will be seen, regardless of their ability to pay. If you need assistance with paying for services received at the DeWeese Health Center, please complete the form below.

First Name: ___________________________ Last Name: _________________________________

Kent State ID: 8_ _ _ _ _ _ _ _ _ Date of Birth (mm/dd/yyyy): _ _ /_ _ /_ _ _ _

Email: ______________________________ Cell Phone: ________________________________

Insurance Company: _____________________________ Subscriber/Member ID: _______________________

☐ Please email me the response to my application ☐ Please call me with the response to my application

Monthly Income: $__________ Monthly Expenses (not including tuition): $_________

Tuition - approximate the percentage of tuition paid by the following sources:

%	Source
	Self
	Parents or Family Members
	Scholarships
	Grants
	Student Loans
	Tuition Waiver

Check One:

☐ I am fully or partially dependent on parents or family for financial support

☐ I have an Independent Financial Status

I attest that the above information is true and accurate.

____ ______________

Patient Signature Date

A representative will respond to your request. For assistance completing this form, please contact the Insurance and Billing department at 330.672.8251.

Received by (UHS staff): ___________________________________ Date: _____________

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☐ Approved – Sliding Scale A – (Self Pay rate)

☐ Approved – Sliding Scale B – (50% of Self Pay rate)

☐ Approved – 100% waived

Effective: ________/______/________ thru ______/______/_______

☐ Rejected – insufficient information

☐ Rejected – does not demonstrate need for assistance because:

Approver: ____ Date: ________________

Notified patient by: ___ phone ____email on date: _____/_______/_________