



University Health Services

Financial Care Assistance Program Application

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. Please note: financial assistance only applies after all insurance options have been exhausted. Exceptions must be approved by the Director of University Health Services.

First Name:

Last Name:

Kent State ID:

Date of Birth (mm/dd/yyyy):

Email: _____ Cell Phone: _____

Insurance Company: _____ Subscriber/Member ID: _____

Is your insurance a Medicaid plan? Please circle Yes or No

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 (must total 100%):

%	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 for non-tuition related expenses

I have an Independent Financial Status (not including tuition)

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:

No insurance

Out-of-network insurance

Out-of-state or out-of-network Medicaid plan

Approved – Sliding Scale A – (Self Pay rate)

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

Effective:

Thru:

Rejected – insufficient information

Rejected – does not demonstrate need for assistance because:

Additional notes:

Approver:

Date:

Notified patient by: phone email on date: