OHIO UNIVERSITY
Student Health and Counseling Services

2 Health Center Drive
Athens Ohio 45701-2979
740.593-1660
740.593.0179

Application for Forgiveness of Counseling and/or Medical Service Charges

Date of Application: _____ Patient's PID#: _____ Class Rank: Undergrad __ Grad __

Patient's Name: _____ Enrolled? YES__ NO__

Address: _____
Street *City* *State* *Zip Code*

Date(s) of Medical or Counseling Service _____

1. Were you an Ohio University Student at the time of your service? YES__ NO__
2. Were you a participant in the WellBeing Plan at the time of your service? YES__ NO__
3. Did you have health insurance at the time of your service? YES__ NO__
4. Did your parents/guardians claim you as a dependant for income tax purposes last year? YES__ NO__

Please provide the following information for all of the people (including yourself) of your immediate family who live in your home. For the purposes of this application, "immediate family" is defined as the patient's spouse and all of the patient's children under the age of 18 (natural or adoptive) who live in the patient's home. ***If you answered yes to item 4 above, please list your parent's/guardian's income below.***

Name	Age	Relationship to patient	Income for 3 months prior to service	Income for 12 months prior to service

Use the reverse to describe financial obligations beyond those listed above that effect your ability to pay medical or counseling charges.

By my signature below, I certify that everything I have stated in this application to be true.

Applicant Signature Date

Approved YES__ NO__ Amount $_____ Reason: _____