



INDIGENT CREMATION PAYMENT APPLICATION AND AGREEMENT

City of Fairlawn
3487 S. Smith Road
Fairlawn, Ohio 44333
330-668-9500

Date submitted: _____

This application must be completed in order to claim payment for indigent cremation. Certain information contained in this application is a matter of public record and subject to disclosure. Any false statement made or given in this application may result in denial of the application and/or criminal prosecution.

SECTION 1: Deceased Person's Information

| | | |
|------------------------|-------------------------------|--|
| Last Name | First Name | Middle Name |
| Address | | Apt. # |
| City | State | Zip |
| Date of Death | Social Security Number | Marital Status at time of death |
| Place of Death: | | |
| Street | City | State Zip |

SECTION 2: Questionnaire

| No. | Questions | (Mark One) |
|-----|---|--|
| 1. | Have the remains of the deceased person been claimed? If yes, provide the following information for the person who claimed the remains of the deceased person: Full Name: _____ Address: _____ Phone Number: _____ Relationship to the deceased person: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 2. | Was the deceased person a legal resident of the City of Fairlawn at the time of death? If yes, provide details below and attach proof of residency (e.g. death certificate, property tax bills, current lease, utility bills, or nursing home records, etc.) Details: _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |



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| No. | Questions | (Mark One) |
|-----|--|--|
| 3. | Was the deceased person a patient at an extended care or nursing home facility at the time of death? If yes, which facility? _____ If yes, what was the amount in the patient care account on the date of death? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 4. | Did the deceased person, at the time of his/her death, receive benefits from the Ohio Dept. of Job & Family Services, Medicaid, or any other similar programs? If yes, indicate the programs applicable: _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 5. | Was the deceased person a veteran? If yes, who will be applying for burial funds? _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 6. | Was the deceased person receiving Social Security retirement, disability, or supplemental income benefits at the time of death? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 7. | Was the deceased person covered by any life insurance policies at the time of death? If yes, provide the name of the insurance company, the policy number, and the amount of coverage, if known: Details: _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 8. | Did the deceased person participate in any type of pre-need or pre-paid funeral/burial plan or funding? If yes, identify the company or agency managing the program: Details: _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 9. | Did the deceased person or does the deceased person's spouse own real estate, automobiles, or other significant tangible assets? If yes, identify and state the location of such assets: Details: _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 10. | Did the deceased person have a bank account or other financial account at the time of death or within the last twelve months prior to death? If yes, list the name of the financial institution(s) and the account number(s): Details: _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 11. | Has or will the body of the deceased person be delivered for the purpose of medical or surgical study or dissection in accordance with Section 1713.34 of the Ohio Revised Code? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |



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**SECTION 3: Funeral Director or Crematory Operator Information
(To be completed by Funeral Home or Cremation Provider Requesting Payment)**

Funeral Home Director: _____
Funeral Home/Crematory: _____
Address: _____
Phone Number: _____
Federal I.D. No. _____

| | |
|---|---|
| <p>Has the funeral director, crematory, or applicant received, or will they receive payments, benefits, or donations from family, non-profit organizations, or any other sources for the purpose of covering funeral, burial, or cremation expenses? If yes, list all such sources and the amount of payments:</p> <p>Details: _____ _____ _____ _____</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> |
|---|---|

SECTION 4: Information of Person Requesting Payment other than Funeral Director or Crematory Operator

| | | |
|--|-------------------|-----------------------|
| Last Name | First Name | Middle Initial |
| Address | | Apt. # |
| City | State | Zip |
| Relationship to the Deceased | | Phone Number |
| <p>Is Applicant: Authorizing funeral or burial services? Yes _____ No _____ Indigent? Yes _____ No _____</p> <p>Indigent means a person whose income does not exceed 150% of the current federal poverty line.</p> | | |
| <p>If claiming indigency, please provide details regarding household income:</p> <p>_____ _____ _____</p> | | |



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SECTION 5: Acknowledgement and Signature

The City of Fairlawn will pay only for the cremation of the deceased resident’s remains and the provision of the simplest and least expensive container available. Eligible charges shall include crematory and container charges less the amount of any payments, contributions, insurance, or property, received for said services. The acceptance of any additional payment for expenses must be disclosed to the City and shall be deducted from any payments by the City.

| Documents Required to Be Included with Application Before Payment Is Rendered. |
|--|
| <input type="checkbox"/> Decedent’s death certificate. |
| <input type="checkbox"/> Itemized invoice for the cremation. |
| <input type="checkbox"/> Proof of indigency (documents/information regarding the decedent’s financial status). |
| <input type="checkbox"/> Burial transit or disposition permit. |
| <input type="checkbox"/> Cremation authorization form. |

I, _____, certify that the above information is a true complete, and accurate
(Applicant)
to the best of my information and belief statement.

I agree that the total amount of reimbursement shall not exceed the maximum allowable under Chapter 254 “Indigent Cremation” of the Codified Ordinances of the City of Fairlawn (i.e., adult \$1,800.00, child (1-17) \$1,400.00 and infant (less than 1 year of age) \$900.00). I further agree that funding must first be sought from other sources and that any funds contributed by any other available source must be revealed and will be deducted from the maximum allowable under the program.

I understand that if I knowingly make a false statement on this application, I can be charged with Falsification in accordance with Section 606.10 of the Code of Ordinances of the City of Fairlawn, Ohio. I further understand that this application is a public record that will be kept on file at the City of Fairlawn and made available for inspection upon request.

Applicant signature

STATE OF OHIO)
) SS.
COUNTY OF SUMMIT)

_____, being duly sworn, deposes and says he or she is authorized to make the foregoing application and that the foregoing statements contained herein are true to the best of his/her knowledge.

Sworn to before me and subscribed in my presence this _____, day of _____, 20__.

Notary Public