Financial Assistance Application Form

This is an application for financial assistance at Wayne HealthCare. Wayne HealthCare provides financial assistance in accordance with state and federal requirements to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. To view Wayne HealthCare's Financial Assistance Policy and additional information, please visit waynehealthcare.org.

SCREENING INFORMATION

1. Where you an Ohio resident at the time of service? ☐ Yes ☐ No
2. Do you have any health insurance including Medicaid Assistance? ☐ Yes ☐ No (if yes, list below)
3. List all health insurance including Medicaid:_____
4. Has the patient applied for Medicaid Assistance? ☐ Yes ☐ No
5. Last date applied for Medicaid Assistance:_____
6. Were you an active recipient of Ohio Department Of Job And Family Services Disability Assistance at the time of hospital service? ☐ Yes ☐ No

PATIENT AND APPLICANT INFORMATION

Patient First Name	Patient Middle Name	Patient Last Name
☐ Male ☐ Female ☐ Other May Specify:_____	Birth Date	Social Security Number
Mailing Address _____ Street _____ City State Zip Code		Main Contact Number (___) _____ (___) _____ Email:_____
Employer Name:		Employer Phone Number:

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together and are under the age of 18. If the patient is of age 18, then they would be their own applicant due to being of legal age.

Family Size:_____

Name	Date of Birth	Relationship to patient	Name	Date of Birth	Relationship to patient

Wayne HealthCare Financial Assistance Application Form - Confidential

FINANCIAL INFORMATION

All adult family members' income must be disclosed. Sources of income include, for example: Wages ■ Unemployment Self-employment ■ Workers Compensation ■ Disability ■ SSI ■ Child/Spousal Support ■ Work Study Programs (Students) Pension ■ Retirement Account Distributions ■ Other Please Explain:_____

Salaries (combined)	$	Military Family Allotment	$
Child Support/Alimony	$	Pensions/Veterans Benefits	$
Public Assistance	$	Rental Income	$
Social Security	$	Unemployment Compensation	$
Grants/Investments	$	Workman's Compensation	$
Farm or Self Employment	$	Other	$

Total persons in family _____ **Total Family Income (add up all income listed above)** $ _____

If you reported $0 Income, please provide a brief explanation of how or whom is meeting you and/or your family's needs.

_____

_____

_____

Effective **JANUARY 13, 2018** you and your family may be eligible for Free Hospital Services if your income falls at or below the State Poverty Guidelines within the last 3 years. Family size > 8, add $4,320 for each additional person.

Family Size	Guidelines	Family Size	Guidelines	Family Size	Guidelines	Family Size	Guidelines
1	$12,140.00	3	$20,780.00	5	$ 29,420.00	7	$ 38,060.00
2	$16,460.00	4	$ 25,100.00	6	$ 33,740.00	8	$ 42,380.00

PATIENT AGREEMENT

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_____ _____

Signature of person applying Date

Applications are valid for 90 days on Out Patient Services

Mail Application
Wayne HealthCare
Attn: Financial Counselor
835 Switzer Street
Greenville, Ohio 45331
Ph: (937) 547-5770
Fax: (937) 547-5789

** WAYNE HEALTHCARE USE ONLY **

DO NOT WRITE BELOW THIS LINE. FOR WAYNE HEALTHCARE OFFICE USE ONLY.

Date Received

Family Size _____ Income (3 or 12 months) _____

Approved HCAP _____ Approved Charity % _____ Denied _____

_____ _____

Hospital Representative Date

Letter Sent ☐ Yes ☐ No