



# 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](http://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
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other May Specify: _____	Birth Date	Social Security Number
Mailing Address	Main Contact Number	
Street	( ) _____	
City	State	Zip Code
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) / Gross Monthly Income	\$ _____	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 11, 2019** 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 \$4,420 for each additional person.

<u>Family Size</u>	<u>Guidelines</u>	<u>Family Size</u>	<u>Guidelines</u>	<u>Family Size</u>	<u>Guidelines</u>	<u>Family Size</u>	<u>Guidelines</u>
1	\$12,490.00	3	\$21,330.00	5	\$ 30,170.00	7	\$ 39,010.00
2	\$16,910.00	4	\$ 25,750.00	6	\$ 34,590.00	8	\$ 43,430.00

## 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

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

*Applications are valid for 90 days on Out Patient Services*

### \*\* WAYNE HEALTHCARE USE ONLY \*\*

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

Family Size \_\_\_\_\_ Income (3 or 12 months) \_\_\_\_\_

Approved HCAP \_\_\_\_\_ Approved Charity % \_\_\_\_\_

\_\_\_\_\_  
Hospital Representative

\_\_\_\_\_  
Date

Date Received
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Denied \_\_\_\_\_

Letter Sent  Yes  No