WAYNE HEALTHCARE **Please return in 15 days**

FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME: _____ SOCIAL SECURITY #: _____

APPLICANT NAME, IF NOT THE PATIENT: _____

(Please answer the following questions as they apply to the patient.)

STREET: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE# _____

DATES OF HOSPITAL/PHYSICIAN SERVICE: _____

EMPLOYER: _____ EMPLOYER PHONE NUMBER: _____

Last Date of applying for Medicaid Assistance. _____

Were you an Ohio resident at the time of service? Yes No (Must be Ohio resident to qualify.)

Do you have any health insurance including Medicaid? Yes No List:

Were you an active recipient of ODJFS Disability Assistance at the time of hospital service? Yes No (Please attach card copy)

Please list **PATIENT** and **IMMEDIATE FAMILY** which consist only of **SPOUSE, NATURAL** and **ADOPTIVE** children under age of 18. **If the patient is of age 18 then they would be their own applicant and income only.**

Name	Date of birth	Relationship to Patient	Name	Date of Birth	Relationship to Patient

EXAMPLES OF HOUSEHOLD GROSS INCOME PER MONTH

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

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

_____

_____

To the best of my knowledge, I attest that the information I have provided is complete and accurate.

_____ _____

DATE APPLICANT'S SIGNATURE

(DO NOT WRITE BELOW THIS LINE) Date Application received _____

Effective **JANUARY 13, 2021.** You and your family members maybe eligible for Free Hospital Services if your income falls below the State Poverty Guidelines within the last 3 years.

Application valid for 90 days on Outpatient Services

FAMILY SIZE	GUIDELINES
1	$12,880.00
2	$17,420.00
3	$21,960.00
4	$26,500.00
5	$31,040.00
6	$35,580.00
7	$40,120.00
8	$44,600.00

Wayne Healthcare
Attn: Financial Counselor
835 Sweitzer Street
Greenville, Ohio 45331
Ph: 1-800-589-2963 or 937-547-5770
Fax: 937-547-5789

With more that 8 persons, a add $4,540.00 for each additional member.

Family Size:_____ Income for 12 months:_____ Denied:_____

Approved HCAP:_____ Approved Charity Percentage:_____ Approval or Denial Letter Sent: YES or NO (Circle One)

Hospital Representative:_____ Date:_____

FINANCIAL ASSISTANCE PROGRAM is available to Wayne HealthCare patients

Thank you for choosing Wayne HealthCare for your healthcare services. We offer financial assistance programs to meet the needs of our patients. A translator service is available.

YOU MAY BE ELIGIBLE TO RECEIVE FREE OR DISCOUNTED CARE: By completing our financial assistance application, this will help Wayne HealthCare determine if you are eligible for free or discounted services. Please complete the application and submit it to the hospital in person, by mail, or by fax (937-547-5789) to apply for the free or discounted care. In completing and signing the application, you acknowledge that you made a good faith effort to provide all information requested in the application to assist Wayne HealthCare in determining your eligibility for financial assistance.

An individual who is eligible for financial assistance may not be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance coverage. Please refer to the full policy for complete details.

Program	Available to	Description	How to apply
Financial Assistance	Uninsured & Insured Patients	Offers free care or discounted care based on family size and income according to the Federal Poverty Guidelines • Free care up to 100% FPG • Discounted care 101-200% FPG	Complete the Financial Assistance Program Application
Payment Plan Program	Uninsured and Insured Patients	Assists patients with their financial obligations by establishing monthly payment arrangements.	Contact a Financial Counselor at 937-547-5770
Uninsured Self –Pay Full Payment Discount	Uninsured Patients	Effective January 01, 2019 regardless of date of service. Offers a 25% discount when paying 30 days after receiving statement.	Contact a Financial Counselor at 937-547-5770

Effective January 13, 2021. You and your family may be eligible for free hospital services, if your income falls at or below poverty income guidelines within the last 3 years.

Family Size	Guidelines
1	$12,880.00
2	$17,420.00
3	$21,960.00
4	$26,500.00
5	$31,040.00
6	$35,580.00
7	$40,120.00
8	$44,600.00

If more than 8 persons, add $4,540.00 for each additional person.

To help us determine if you are eligible for assistance, please complete, sign, date and return the application along with statement of income completed. An individual that is approved for financial assistance may not be charged more than the AGB for emergency or other medically necessary care. **THE APPLICATION IS ON THE BACK SIDE OF THE STATEMENT.**

1. If you report zero income please provide a brief explanation stating how you are living and if someone else is supporting you. We need to know how long you have been unemployed and if you have applied for Medicaid or a Medicaid program.

Return completed form and supporting documents to:

Wayne HealthCare
Financial Counseling
835 Sweitzer Street
Greenville, OH 45331

We will respond to you within 15 days of receiving your completed application and supporting documents. If you have any questions or need additional assistance, please contact us at 800-589-2963, extension 6947, or 937-547-5770. Our fax number is 937-547-5789. Additional information is available on our website at: www.waynehealthcare.org. ***Greenville Emergency Physicians, Radiologists, Anesthesia, and EKG Reading charges are not a part of Wayne HealthCare's Financial Assistance Program.***