WAYNE HEALTHCARE FINANCIAL ASSISTANCE APPLICATION **Please Return Within 15 Business Days**

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: _____ TELEPHONE # _____ CELL #: _____

DATE(S) OF HOSPITAL SERVICE: _____ 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

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 Only, Which Consist Of **SPOUSE**, **NATURAL** Or **ADOPTIVE** CHILDREN Under Age 18.

If The Patient Is Of Age 18, Then They Would Be Considered Their Own Applicant With Their Income Only.

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

Please Provide 13 Weeks (3 Months) Income Prior To Hospital Date Or 12 Month Income Prior To Hospital Date Of Services

Salaries (combined)	$_____	Farm or Self Employment	$_____	Income 3 Months Prior
Child Support	$_____	Military Family Allotment	$_____	To Hospital Service Date
Alimony	$_____	Pensions/Veterans Benefits	$_____	$
Public Assistance	$_____	Unemployment Compensation	$_____	
Social Security	$_____	Workman's Compension	$_____	Income 12 Months Prior
Rental Income	$_____	Other $ (Please Explain)	$_____	To Hospital Service Date
Grants/Investments	$_____			$
Total persons in family	_____	**Total Family Income $**		

If You Report **$0.00 Income**, Please Provide A Brief Explanation Of How Or Whom Is Providing Your Financial 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)

Effective **JANUARY 16, 2023.** 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 30 days on Inpatient Services

Application valid for 90 days on Outpatient Services

FAMILY SIZE	GUIDELINES
1	$14,580.00
2	$19,720.00
3	$24,860.00
4	$30,000.00
5	$35,140.00
6	$40,280.00
7	$45,420.00
8	$50,560.00

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

With More Than 8 Add $5,140.00 For Each Additional Person

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

Approved HCAP: _____ Approved Charity Percentage: _____ Approval or Denial Letter Mailed: Yes or No

Hospital Representative: _____ Date: _____ Rev Revised: 01/16/2023