WAYNE HEALTHCARE FINANCIAL ASSISTANCE APPLICATION Please Return within 15 Days.

PATIENT NAME:____SOCIAL SECURITY NUMBER_____________ ________________

Applicant Name If Not The Patient:____

Please answer the following question's as they apply to the Patient

ADDRESS:____ ________________

CITY:__________________________STATE:_________ZIP CODE:____________TELEPHONE:________________ ________________

EMPLOYER:____EMPLOYER PHONE NUMBER:________________ ________________

DATES OF HOSPITAL/PHYSICIAN SERVICE:____ ________________

Were You An Ohio Resident At Time Of Service: Yes or No Must Be Ohio Resident To Qualify

Last Date Of Applying For Medicaid Assistance:____ ________________

Were You An Active Recipient Of ODJFS Disability At Time Of Service: Yes or No (Please Attach Copy Of Card)

Do You Have Any Health Insurance Including Medicaid: Yes or No Please List Name:________________________

Please List PATIENT And IMMEDIATE FAMILY Only In Which Consist Of SPOUSE, NATURAL, ADOPTIVE Children Under The 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	Income For 3 Months Prior To Hospital Service Date (13 Weeks of Income)	Income For 12 Months Prior To Hospital Service Date
Total Person(s) In Family:			Total Family income: $	

Examples Of Household Gross Income: Salaries (Combined), Social Security, Pension/Veterans Benefit, Child Support, Alimony, Worker's Compensation, Farm/Self Employment, Military, Unemployment, Rental Income, Disability, Grants/Investments, Public Assistance.

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

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To the Best Of My Knowledge. I Attest That The Information I Have Provided Is Complete And Accurate.

DATE:___________________________APPLICANT SIGNATURE:_______________________________________

Effective **JANUARY 12, 2022.** 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 Outpatient Services. Application Valid For 30 Days Inpatient Services.

FAMILY SIZE	INCOME GUIDELINES
1	$13,590.00
2	$18,310.00
3	$23,030.00
4	$27,750.00
5	$32,470.00
6	$37,190.00
7	$41,910.00
8	$46,630.00

With More Than 8 Add $4,720.00 For Each Additional Person

Return To: **Wayne Healthcare**
Attn: Financial Counselor
835 Sweitzer St.
Greenville, OH 45331
Ph: 937-547-5770 Or 800-589-2963
Fax: 937-547-5789

Family Size:________ Income For 12 Months:____________________________Denied:________________________

Approved HCAP:_________________Approved Charity Percentage:_______________Approval Or Denial Letter Mailed: YES or NO

Hospital Representative:____Date:_________________________________ REV: 01/20/2022