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 15, 2020.** 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	$12,760.00
2	$17,240.00
3	$21,720.00
4	$26,200.00
5	$30,680.00
6	$35,160.00
7	$39,640.00
8	$44,120.00

With more that 8 persons, add $4,480.00 for each additional member.

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

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:_____