Van Wert Health

Financial Assistance Application

Please complete all fields, and sign where indicated. Please provide all types of gross family income, such as employment, unemployment compensation, social security, pensions, self-employment, disability, workers compensation, etc. Ohio hospitals are required by law to provide medically necessary hospital services free of charge to any eligible person. If you meet the Federal Poverty Guidelines (see the chart), fill out this form and return it to the Financial Counselor at Van Wert Health.

PATIENT NAME ______________________________ SOCIAL SECURITY # ____________________

PHONE # ______________ APPLICANT NAME, IF NOT PATIENT ______________________________
(If the applicant is not the patient, please answer the following questions as they apply to the patient.)

STREET ______________________________ CITY ______________ STATE ________ ZIP ______________

EMAIL ____
(If you would like to receive communication regarding application via email, please provide your email address.)

DATE(S) OF HOSPITAL SERVICE: FROM: ____________________ TO: ____________________

Were you an Ohio resident at the time of your hospital service? ☐ YES ☐ NO
If yes, county: ____________________

Were you an active Medicaid recipient at the time of your hospital service? ☐ YES ☐ NO
If yes, Medicaid recipient ID number: ____________________

Were you an active recipient of Disability Assistance at the time of your hospital service? ☐ YES ☐ NO
(If yes, please attach a copy of your DA card effective during your hospital service to this application)

Did you have health insurance (other than Medicaid) at the time of your hospital service? ☐ YES ☐ NO

If auto related, do you have auto insurance covering this date of service? ☐ YES ☐ NO
If yes, what is the insurance company name? ____________________
Adjuster name: ____________________ Phone: ____________________

Annual income must be at or below the following amounts according to family size

INCOME STATUS COMPARED TO 2020 FEDERAL POVERTY LEVELS

Family Size	100% HCAP	60% HCAP
1	$ 12,880	$ 25,520
2	17,240	34,480
3	21,960	43,440
4	26,500	52,400
5	31,040	61,360
	Add $4,540.00 for each additional person	Add $8,960.00 for each additional person

Patient Account Representatives are available Monday - Friday from 8 AM - 4 PM | 419-238-8668

Form revised June 2021

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Please provide the following information for all of the people in your immediate family who live in your home. Family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the Family shall include the patient, the patient's natural or adoptive parent(s), children under 18 (natural or adoptive) who live in the patient's home.

PATIENT NAME	AGE/DATE OF BIRTH	RELATIONSHIP TO PATIENT	GROSS INCOME FOR 3 MONTHS PRIOR TO HOSPITAL SERVICE	GROSS INCOME FOR 12 MONTHS PRIOR TO HOSPITAL SERVICE
		PATIENT		
NAME(S) OF IMMEDIATE FAMILY MEMBER LIVING IN HOME	**AGE/DATE OF BIRTH**	**RELATIONSHIP TO PATIENT**	**GROSS INCOME FOR 3 MONTHS PRIOR TO HOSPITAL SERVICE**	**GROSS INCOME FOR 12 MONTHS PRIOR TO HOSPITAL SERVICE**
TOTAL PERSONS IN FAMILY		**TOTAL FAMILY GROSS INCOME**		

*If you reported no income, please include an explanation of how you exist financially.
(For example, if you live with a friend who pays for expenses, etc.)

By my signature below, I certify that everything I have stated on this application and on my attachments is true:

Responsible Party's Signature _______________________ Date _______________

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