VAN WERT HEALTH FINANCIAL APPLICATION

Van Wert Health

PATIENT NAME: _____ SOCIAL SECURITY # _____ PHONE # _____

APPLICANT NAME, IF NOT PATIENT _____ DATE _____

(If the applicant is not the patient, please answer the following questions as they apply to the patient.)

STREET _____ CITY _____ STATE: _____ ZIP _____

DATE(S) OF HOSPITAL SERVICE FROM _____ TO _____

1. Were you an Ohio resident at the time of your hospital service?	YES ☐ NO ☐
2. Were you an active Medicaid recipient at the time of your Hospital service? If yes, Medicaid recipient ID number:	YES ☐ NO ☐
3. Were you an active recipient of Disability Assistance at the time of your hospital service? (If you answered yes to this question, please attach a copy of your DA card effective during your hospital service to this application)	YES ☐ NO ☐
4. Did you have health insurance (other than Medicaid) at the time of your hospital service?	YES ☐ NO ☐

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 eighteen, the Family shall include the patient, the patient's natural or adoptive parent (s), and the parent (s), children under 18 (natural or Adoptive) who live in the patient's home.

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
TOTAL PERSONS IN FAMILY		TOTAL FAMILY GROSS INCOME		

*If you reported no income, please use the reverse side of this paper for an explanation of how you exist financially. (IE: 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 any attachments is true.

_____ _____

Applicant Signature Date

If you have significant medical expenses that you would like to have considered, please describe _____

_____

_____

Please see reverse side of paper for income qualifications

Please contact the Business Office at 419-238-2390 x 640 or 419-238-8646, (1-800-686-3963)
See a Registration Staff Member for program information

VAN WERT HEALTH FINANCIAL APPLICATION

Van Wert Health

Response space for financial existence (please respond only if you reported having no gross income) _____

Income Qualifications

Family Member Size	Yearly Income at or Below to Qualify for HCAP	Yearly Income at or Below to Qualify for Hope Program - 60% Discount	Yearly Income at or Below to Qualify for Hope Program - 40% Discount
1	$ 12,060	$ 23,999.40	$ 36,059.40
2	16,240	32,317.60	48,557.60
3	20,420	40,635.80	61,055.80
4	24,600	48,954.00	73,554.00
5	28,780	57,272.20	86,052.20
6	32,960	65,590.40	98,550.40
7	37,140	65,590.40	111,048.60
8	41,320	82,226.80	123,546.00
9+	Add $4,180.00 for each additional person	Add $8,318.20 for each additional person	Add $12,498.20 for each additional person

Please contact the Business Office at 419-238-2390 x 640 or 419-238-8646, (1-800-686-3963)
See a Registration Staff Member for program information