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 2022 FEDERAL POVERTY LEVELS

Family Size	100% HOPE	60% HOPE
1	$ 13,590	$ 27,180
2	18,310	33,458
3	23,030	39,736
4	27,750	46,014
5	32,470	52,292
	Add $4,720 for each additional person	Add $6,278 for each additional person

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

Form revised March 2022

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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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