VAN WERT COUNTY HOSPITAL FINANCIAL APPLICATION

PATIENT NAME: _____ SOCIAL SECURITY #_____ PHONE #_____ Date:_____

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:_____

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? YES___ NO___

If yes, Medicaid recipient ID number:_____

3. Were you an active recipient of Disability Assistance at the time of your hospital service? YES___ NO___

(If you answered Yes to this question, please attach a copy of your DA card effective during your hospital service to this application)

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:**		

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 reported no income-Please use another paper for an explanation of how you exist financially. (Example: live with a friend who pays for expenses, etc.,)

2017 Federal Poverty Guidelines

FAMILY MEMBER SIZE	MAXIMUM YEARLY INCOME AT OR BELOW TO QUALIFY FOR HCAP	YEARLY INCOME AT OR BELOW TO QUALIFY FOR HOPE PROGRAM	ANNUAL INCOME AT OR ABOVE TO QUALIFY FOR A PAYMENT PLAN
1	**$12,060**	**$23,999.40**	**$24,120**
2	**$16,240**	**$31,317.60**	**$32,480**
3	**$20,420**	**$40,635.80**	**$40,840**
4	**$24,600**	**$48,954.00**	**$49,200**
5	**$28,780**	**$57,272.20**	**$57,560**
6	**$32,960**	**$65,590.40**	**$65,920**
7	**$37,140**	**$73,908.60**	**$74,280**
8	**$41,320**	**$82,226.80**	**$82,640**
	ADD $4,180 FOR EACH ADDITIONAL PERSON	**ADD $8,318.20 FOR EACH ADDITIONAL PERSON**	**ADD $8,360 FOR EACH ADDITIONAL PERSON**

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

_____

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