

**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
<b>TOTAL PERSONS IN FAMILY:</b>		<b>TOTAL FAMILY GROSS INCOME:</b>		

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.)

Family Member Size	Maximum 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	\$73,908.60	\$111,048.60
8	\$41,320	\$82,226.80	\$123,546.80
	Add \$4,180.00 for each additional person	Add \$8,318.20 for each additional person	Add \$12,498.20 for each additional person

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