WYANDOT MEMORIAL HOSPITAL

HCAP / Charity Care Application

Patient Name: Last	Fir	rst	M.I	Patient MRN#	
Guarantor Name: Last	Fir	rst	M.I	Guarantor #	
Address: Street	City			State: Zip:	
Phone No Dates of Service:					
MARITAL STATUS: (Please Circle one)	SINGLE MARRIE	ED SEPARATE	ED DIVORC	ED WIDOWED	
Was there health insurance coverage for the service? Yes No If yes, list insurance name:					
Were you an Ohio resident at the time of the service? YesNo		_	Insurance Policy #		
Were you an active Medicaid recipient at the time of the service? Yes No If yes, Medicaid #					
PROVIDE THE FOLLOWING INFORMATION FOR ALL OF THE PEOPLE IN YOUR IMMEDIATE FAMILY. FOR HCAP: "FAMILY" IS DEFINED AS THE PATIENT, THE PATIENT'S SPOUSE(REGARDLESS WHETHER THEY LIVE IN PATIENT'S HOME), AND ALL PATIENT'S CHILDREN UNDER 18 (NATURAL OR ADOPTED) WHO RESIDE WITH THE PATIENT.					
Family Members Name	Age Relationship to	List Employer or I	Hire/StartDate	Income for 3 months Income for 12 months	
	Patient	Source of Income		Prior to Hospital Serv Prior to Hospital Serv	
		(SS, Pension, etc.)			
			TOTAL		
ATTACH INCOME VERIFICATION (THIS INCLUDES PAY STUBS OR OTHER DOCUMENTS THAT SHOW THE INCOME FOR THE 3 MONTHS PRIOR TO THE OLDEST DATE OF SERVICE OPEN). ***** IF YOU REPORTED \$0.00 INCOME – YOU MUST PROVIDE A WRITTEN EXPLANATION OF HOW YOU WERE BEING SUPPORTED. ***** IF YOU NO LONGER ARE WORKING, PROVIDE LAST DATE WORKED AND IF RECEIVING UNEMPLOYMENT.					
VALUE OF ASSETS: WYANDOT MEMORIAL REQUIRES A VERIFICATION OF ASSETS- THIS WILL INCLUDE YOUR CHECKING AND SAVINGS BALANCES. ***** YOU MUST ALSO ATTACH YOUR LAST BANK STATEMENT THAT WILL SHOW THE CHECKING AND SAVINGS BALANCES.					
CURRENT CHECKING ACCOUNT BALANCE \$ CURRENT SAVINGS ACCOUNT BALANCE \$					
"I certify that the above information is true and accurate to the best of my knowledge. Further, I will apply and take any reasonable action needed to get assistance (Medicaid, Medicare, auto insurance, etc.) to pay my hospital charges. Financial assistance with the hospital will be a source of last resort. Any other liability or possible payer must be exhausted prior to awarding assistance. "I understand that this application is made so that the hospital can see if I am eligible for HCAP or charity care assistance based on the defined criteria. If					
any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status. The hospital may take whatever action is appropriate. I authorize Wyandot Memorial Hospital to obtain financial information from other sources such as a credit report or property search and/or information from a collection agency, if needed.					
Application Signature				Date	
RETURN APPLICATION TO: WYANDOT MEMORIAL HOSPITAL			ICE USE ONLY:	Worked	
Attn.: Patient Accounts Division		Initial DOS:	: No	otes:	
885 North Sandusky Avenue		Approved _	Denied	Program:	
Upper Sandusky, OH 43351		Reviewer Si	ignature:		
If questions call - (419) 294-4991, ext. 1051		Date	Applic	ant Notified: LtrPhone	