**WYANDOT MEMORIAL HOSPITAL HCAP / Charity Care Application**

Patient Name: Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_\_\_\_ Patient MRN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor Name: Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_\_\_\_ Guarantor # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: (Please Circle one) SINGLE MARRIED SEPARATED DIVORCED 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? Yes \_\_\_\_\_ No \_\_\_\_\_ 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 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.)

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 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 ARE SELF-EMPLOYED, WE MUST HAVE A COPY OF THE MOST RECENT INCOME TAX RETURN. \*\*\*\*\* 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 THE LAST DATE WORKED AND IF RECEIVING UNEMPLOYMENT.

ATTACH VALUE OF ASSETS: \*\*\*\*\*WYANDOT MEMORIAL REQUIRES VERIFICATION OF ASSETS- THIS WILL INCLUDE YOUR CHECKING AND SAVINGS BALANCES. \*\*\*\*\* YOU MUST ATTACH YOUR LAST BANK STATEMENT THAT WILL SHOW THE CHECKING AND SAVINGS BALANCES.

 “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: WMH OFFICE USE ONLY:

WYANDOT MEMORIAL HOSPITAL Date Application Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worked \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attn.: Patient Accounts Division Initial DOS: \_\_\_\_\_\_\_\_\_\_\_\_\_ Coverage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

885 North Sandusky Avenue Approved \_\_\_\_\_\_\_\_ Denied\_\_\_\_\_\_\_\_\_ HCAP CHARITY CARE

Upper Sandusky, OH 43351 Reviewer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If questions call - (419) 294-4991, ext. 2016 Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Applicant Notified: Ltr \_\_\_\_\_ Phone \_\_\_\_\_ (6.22.23)