WILSON HEALTH
Caring Without Limits

Hospital Financial Assistance Application

DIRECTIONS FOR COMPLETING THIS 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, alimony, child support, etc.

Patient Name: _____ **Applicant Name (if NOT the Patient):** _____
If the applicant is not the patient, please complete the application as it applies to the patient for the date of service you are applying for

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Marital Status on Date of Service: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

1) Were you an Ohio Resident at the time of your hospital service? ☐ Yes ☐ No
2) Were you an active recipient of Disability Assistance at the time of your hospital service? ☐ Yes ☐ No
3) Were you an active Medicaid recipient at the time of your hospital service? ☐ Yes ☐ No
   If yes, Medicaid recipient ID number: _____
4) Did you have health insurance (other than Medicaid) at the time of your service? ☐ Yes ☐ No

Account #: _____ **Date(s) of Service:** **From**_____ **Thru**_____

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Please provide the following information for yourself and your immediate family members that live in your home. For the purposes of this application, Family is defined as the patient, the patient's spouse (regardless of whether spouse lives in the home), 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) (regardless of whether both parents live in the home), and the parent(s)' children under 18 (natural or adoptive) who live in the patient's home. If the patient is the child of a minor parent who still resides in the home of the patient's grandparents, the "family" shall include only the parent(s), and any of the parent(s) children, natural or adoptive who reside in the home.

Name	Birthdate	Relationship To Patient	Gross Income for 3 months Prior to service date: From: Thru:	Gross Income for 12 months Prior to service date: From: Thru:	Source of Income- Employer Name
Patient:		***Self***			

IF YOU REPORTED $0 INCOME ABOVE, PLEASE EXPLAIN HOW YOU (OR THE PATIENT) SURVIVED FINANCIALLY DURING THE 3 AND/OR 12 MONTHS PRIOR TO THE DATE OF SERVICE: _____

By my signature below, I certify that everything I have stated on this application and on my attachments is true.

Applicant Signature_____ Date _____

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