

Wabash General Hospital
Prescreening for Charity Care

Instructions:

The following information should be obtained in order to determine the patient's or in the case of a minor, the guardian's or parent's inability to pay.

1. Do you have health insurance coverage? **Y or N**
2. Are you potentially eligible for assistance through the state, county, or other public funded programs? **Y or N**

3. Have you experienced an event subsequent to the admission that may change your ability to pay? **Y or N**
Example: medical complications that have dramatically increased or a substantial change in your financial status.

4. How many family members are in your immediate household? _____
Please list name and relationship.

5. List all sources of **household** income and attach documentation.

I hereby certify that the information provided on this form and attachments are true and complete to the best of my knowledge. I also authorize Wabash General Hospital to verify the income figure I have provided. I agree to report any change in my financial condition to Wabash General Hospital so that the appropriate adjustments can be made. I agree to make arrangements to pay any balance due after the charity deduction is applied.

Signature

Date

