Wabash General Hospital
Financial Assistance Application Form

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help Wabash General Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SERCURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required, but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

Patient Information:

Patient Name: _____ **Date of Birth**: _____

Social Security Number: ____ ____ ____ / ____ ____ / _____ _____ _____ _____

Address: _____ **Phone:** _____

_____

_____

Guarantor Information: (In the case the patient is a minor child.)

Guarantor Name: _____ **Phone:** _____

Address: _____

_____

_____

Family/Household Information:

1. Number of persons in the patient's family/household _____
2. Number of persons who are dependents of the patient _____
3. Age of dependents _____, _____, _____, _____, _____, _____

Patient's Family Income and Employment Information:
(If the patient is a minor, complete Guarantor and Spouse columns, if applicable. If the patient is over the age of 18, complete the Patient and Spouse columns, if applicable.)

	Patient	Guarantor	Spouse (Partner)
✓ column of who is currently employed			
Name of Employer			
List Monthly Income Amounts			
Wages			
Unemployment Compensation			
Social Security			
Disability Income			
Worker's Compensation			
Temporary Assistance			
Retirement (Pension)			
Child Support or Alimony			
Other Income			
Totals			

Include Proof of Income with Application:

The following are examples of acceptable proof of income used for the determination of financial assistance. It is the discretion of Wabash General Hospital to determine acceptable proof of income.

- Current Federal Income Tax Return (Preferred proof of income)
- W-2's
- Letter showing current eligibility for assistance
- Current Pay Stubs
- Unemployment Compensation Letter/Notice
- Recent LES for Military Personnel
- Divorce Decree
- Copy of Student Financial Aid Application with determination notice
- Food Stamp Document showing current eligibility

- Social Security Administration Benefit Letter
- Current Bank Statements (Past 3 months)

Insurance Benefit Information:

1. Do you have health insurance coverage? Y or N
   If yes, do you have:
   Medicare? Y or N
   Medicare Part D? Y or N
   Medicare Supplement? Y or N
   Medicaid? Y or N
   Veterans' Benefits? Y or N

2. Have you enrolled in the State Medicaid plan or Marketplace? Y or N

Certification Statement:

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Signature of Patient or Applicant: _____

Date: _____