COMMUNITY HOSPITALS AND WELLNESS CENTERS
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909 E. Snyder Ave. Montpelier, OH 43543-1271 Ph (419)485-3154 Fax (419)636-5781
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FINANCIAL ASSISTANCE APPLICATION

Date:_____

Patient Name: _____ Date of Birth: _____ Phone #: _____

Applicant Name:_____ Spouse Name:_____

Address: _____ City: _____ State: _____ Zip: _____

Date(s) of Hospital Service: _____

1. Were you an Ohio resident at the time of your hospital service? Yes _____ No _____
2. Did you have Medicaid at the time of service? Yes _____ No _____
3. Did you have health insurance or other auto/liability insurance at the time of service? Yes _____ No _____
   (Please attach a copy of Medicaid or Insurance card that has not paid on this bill)

Please provide the following information for all the people in your family who live in your home. For purposes of HCAP, "family" is defined as the patient, patient's spouse, & all of the patient's children under 18 (natural or adoptive) who live in the patient's home. Gross income is prior to taxes & other deductions.

Name	Age	Relationship To Patient	Gross Income 3 Months Prior To Date of Service	Gross Income 12 Months Prior To Date of Service	Type of Income Verification Attached *
Total Persons in Family:		Total Income:			

*** Proof of income is required, including but not limited to pay stubs, employer payroll print out for the requested months, social security statement, unemployment statement, child support, alimony, workers comp, pension, VA benefits, food stamps and other investment income (tax returns and W2s may be used for some accounts)**

If zero income is reported, provide an explanation of how the patient is supporting himself/herself:

_____

Current monthly gross income (before taxes & other deductions) for all family members living in home _____

List the value of all cash assets and send proof of all balances (enter 'none' for any accounts that you don't have)

Health / Medical Savings Account: $_____
Savings Account(s): $_____
Money Markets: $_____
Mutual Funds: $ _____
Other Cash Assets: $_____

Property Values (exclude primary residence): $_____
Checking Account(s): $_____
Stocks/Bonds: $_____
Certificate of Deposit: $_____

(Additional information to assist CHWC in determining your financial need can also be noted on the back of this form, including extraordinary medical or other expenses)

Financial assistance provided by CHWC may be reversed if the information is not correct. Providing false information to induce another to extend credit, or to bestow any other valuable benefit may be a violation of the Ohio Revised Code Section 2921.13.

By my signature below, I affirm the information on this application is true to the best of my knowledge.

SIGNATURE _____ DATE _____