Wexner Medical Center

FOR ASSISTANCE PAYING YOUR ACCOUNT

Effective 5/22/92, all Ohio hospitals are required by law to provide medically necessary hospital services, free of charge to any eligible person (HCAP). If you meet the Federal Poverty Guidelines or wish to be considered for other financial assistance programs, complete the entire form below and return it to the OSU Medical Center.

If you need further assistance in paying your OSU Wexner Medical Center bill, call 614-293-2100.

Patient's Name______________________________ Date of Birth ______________

Address: ____

Medical Record Number (for office use only): ____________________

1) Was the patient a resident of Ohio at the time of service? .... Yes_____ No_____

2) Was the patient a citizen of the United States at the time of service? .... Yes_____ No_____

3) Did the patient have Medical Insurance at the time of service? .... Yes_____ No_____

4) Was the patient an active Medicaid recipient at the time of service? .... Yes_____ No_____

5) Was the patient an active recipient of Ohio Disability Assistance at the time of service?.. Yes_____ No_____

If you answered **yes** to question 3, 4, or 5 please attach a copy of your insurance, Medicaid, or DA card to this application

Date(s) of service applying for: From ________________ to ________________

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of HCAP, "family" is defined as the patient, the patient's spouse (living in the home or not) and all of the patient's children under 18 (biologic or adoptive) who live in the patient's home. (add additional pages as necessary)

Name	Age	Relationship to Patient	Number of months income received of the 3 months prior to date of service	Number of months income received of the12 months prior to the date of service	Hourly Rates: Hourly Rate	Hourly Rates: Average Number of Hours Worked per Week	Or	Non-hourly Rates (includes SSI, pension, alimony, unemployment or other income) Include the benefit type and pay frequency
		patient					Or	
							Or	
							Or	
							Or	
							Or	

Please check type of income verification attached: Income verification must include the 3 and/or 12 months PRIOR to the service date. (please send copies – originals will not be returned)

- ❑ Copies of Pay Stubs
- ❑ Social Security / Pension / Disability benefit letter
- ❑ Letter from employer stating gross income
- ❑ Unemployment benefit verification
- ❑ Verification of **any** income received

If you report a **$0 income**, please attach a brief explanation of how you survived financially for the 3 and/or 12 months prior to the date of service. If you receive support from someone, please have that person provide a letter stating the time period they have supported you and the type of support they have provided.

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

______________________________ ____________
Applicant's signature Date

______________________ (____)____________
Relationship to Patient Phone Number

Return this form with income verification to:
OSU Wexner Medical Center
Financial Assistance Department
PO Box 183107
Columbus, OH 43218-3107
Fax #: 614-293-2260

Comments (office use only): ____

Office Use Only
Reviewed by: __________ Scan to FIN-ASST