

Blanchard Valley Hospital and Bluffton Hospital

1900 S. Main St., Findlay, Ohio 45840

139 Garau St., Bluffton, Ohio 45817

Financial Assistance Application (Hospital Charges Only)

TO AVOID ANY DELAYS please complete all sections below

Section I • Patient Identification

PATIENT NAME: _____ ACCOUNT _____

APPLICANT NAME, IF NOT PATIENT: _____

****If the applicant is not the patient, please answer the following questions as they apply to the patient.*

STREET: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: _____ SS#: _____

DATE(S) OF HOSPITAL SERVICE: From _____ To _____

- Was this Service related to an auto accident, work injury or third party liability claim? Yes _____ No _____
If yes, which one? _____
- Is there any attorney representation or settlement expected? Yes _____ No _____
- Were you an Ohio resident at the time of your hospital service? Yes _____ No _____
- Were you an active Medicaid recipient at the time of hospital service? Yes _____ No _____
If yes, Medicaid recipient ID number: _____
- Were you an active recipient of Disability Assistance at the time of hospital service? Yes _____ No _____
(If you answered yes to this question, please attach a copy of your DA card effective during your hospital service to this application.)
- Did you have health insurance (other than Medicaid) at the time of hospital service? Yes _____ No _____

Section II • Income Verification

MONTHS WORKED: (Circle the month(s) below that you worked for each given year.)

LAST YEAR
Patient: J F M A M J J A S O N D
Spouse: J F M A M J J A S O N D

CURRENT YEAR
Patient: J F M A M J J A S O N D
Spouse: J F M A M J J A S O N D

Please provide the following information for **ALL** of the people in your **IMMEDIATE FAMILY** who *live* in your home. (Refer to guidelines on back of the page for definition of family.)

*Note:

1. To check for HCAP eligibility, please see the guidelines on the back of this form. Income verification documents are not required to qualify for HCAP program. However, if you wish to be considered for the hospital based charity assistance program, then income verification documents are MANDATORY.
2. Income verification documents includes pay stubs, W-2, income tax return or other documents containing income information for the appropriate time period (3 or 12 months prior to hospital service).

Name	Age	Relationship to Patient	Income for 3 months prior to hospital service*	Income for 12 months prior to hospital service*
(Patient)		Self		
Total persons in family		Total family income		

If you reported your income as Zero, please provide a brief explanation of how you are being supported: _____

APPLICABLE FEDERAL INCOME GUIDELINES

**HEALTH CARE ASSURANCE PROGRAM
2011**

FAMILY SIZE	INCOME GUIDELINES
1	\$10,890
2	\$14,710
3	\$18,530
4	\$22,350
5	\$26,170
6	\$29,990
7	\$33,810
8	\$37,630

For family units with more than 8 members, add \$3,820 for each additional family member.

*The **family** is defined as parent(s), spouse, and all children natural or adoptive, under the age of eighteen who reside in household.*

If you are eligible for this program, please fill out the form on the back of this page.

1] Return in person to the cashier's office located in the Center for Diagnostic Studies.

OR

2] Mail the form to:

Blanchard Valley Hospital
Attn: Financial Assistance
1900 South Main Street
Findlay, Oh 45840

Subject to government regulated increases, decreases or discontinuation. Effective 01/20/11

Section III • Consent

I hereby submit the above statement for the purpose of allowing **Blanchard Valley Hospital** to evaluate my financial status and determine my eligibility for various financial assistance programs, and do hereby authorize **BVHA** to verify this information as necessary, which may include a credit bureau report, employment and/or income verification, and appropriate supporting documents.

I attest that the above information and all documentation provided are completed and accurate as shown. I realize that should, at any time, any of this information prove to be false, all free care grants awarded will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances.

In addition, I realize that any money received to me by an insurance company or Third Party Liability Award, due to services performed for the specific dates of service covered by this application, could result in the Financial Assistance Award being reversed and I will accept responsibility for full and immediate payment of any and all outstanding balances.

By applying for Financial Assistance, I also agree to accept payment responsibility for any amount due from me as a result of any partial Free Care grant, which may be awarded.



(Patient/ Guarantor Signature)



Date

* If you have any further questions, please call our office at 419-423-5310 Monday - Friday, 8:00-4:30pm.