OhioHealth

Individuals with income at or below the federal poverty guidelines are eligible for services without charge.
Please see the chart on the right.
To apply, complete the application on the reverse side and fax to 419-526-8387 or mail your application along with income documentation to:

OhioHealth Mansfield and Shelby Hospitals
Attention: Financial Assistance Department
335 Glessner Avenue
Mansfield, OH 44903-9989

Financial assistance is available for those with income at or below 400% of the federal poverty guidelines and meets other qualifications.

| 2019 Federal Poverty Guidelines | |
|---|---|
| Size of Family | Yearly Income Level |
| 1 | $12,490 |
| 2 | $16,910 |
| 3 | $21,330 |
| 4 | $25,750 |
| Each Additional Person | $4,420 |

# Tips for Completing the Financial Assistance Application

*Please print legibly and use a ball point pen. Do not use gel pens.
*Do not use "N/A" in any field.
* To make corrections, please put a line through the incorrect information, write in the correct information and initial the change.

| ***Field Description*** | ***Details*** |
|---|---|
| **Name/Address/Phone Number** | Name, address and phone number (including area code) of patient |
| **Account Number** | Enter the account number from the front of the statement. If the account number is not available, leave the box blank |
| **Family Members Name** | List by name, the family members in the immediate family, including yourself, spouse, children under 18(natural or adoptive) who reside in the home |
| **Age** | List the age of each family member next to their name |
| **Relationship** | List how this person is related to the patient. Example: Self, Spouse, Child(natural or adoptive), etc. |
| **Source of Income or Employer Name** | List the employer's name or any other source of income for this person. This would include unemployment, social security, VA, pensions, etc. |
| **Hire/Start Date for all Income** | List the start or hire date at this job, or the date the benefits began, such as with unemployment, social security, retirement, etc. |
| **Income for 3 Months Prior to: Date of Service or Date of Application** | Enter amount of gross income each person received 90 days before the service or date of application. If there is no income 90 days prior to service, enter 0 |
| **Income for 12 Months Prior to: Date of Service or Date of Application** | Enter amount of gross income each person made 12 months before the service or date of application. If there is no income 12 months prior to service, enter 0 |
| **If you wrote $0.00 for income, provide an explanation of how you were being supported** | Explain your means of support (including the names and phone numbers of the individual(s) supporting you) since there was $0.00 income for 3 months prior to the date of service or date of application. Example: My parents supported me – Mark & Jane Smith 614.111.1111 |
| **Value of Assets** | List any checking account money, savings, 401K's, 403B's, IRA's, etc. List all property, cars, boats, etc. If there are none, enter 0 |
| **Monthly Total Expenses** | Total amount of house/rent payment, car payment, utilities, food, etc. |
| **Applicant's Signature** | Sign and date the application |

**NOTE: Make sure the account number is written at the top of all papers sent with application.**
**Do not staple documents.**
**Failure to follow these steps or an incomplete application could result in a delay in processing.**

(1/14/19)