

APPLICATION FOR FINANCIAL ASSISTANCE

If you have any questions please call the Financial Assistance Representative at 740-356-7639 or 740-356-7645.

Family Size	HCAP Yearly Income 100% Discount	Charity Yearly Income 100% Discount	Charity Yearly Income 75% Discount	Charity Yearly Income 50% Discount	Charity Yearly Income 25% Discount	Charity Yearly Income 15% Discount
1	\$ 10,830	\$10,831 - \$13,538	\$13,539 - \$18,213	\$18,214 - \$22,888	\$22,889 - \$27,563	\$27,564 - \$32,238
2	\$ 14,570	\$14,571 - \$18,213	\$18,214 - \$22,888	\$22,889 - \$27,563	\$27,564 - \$32,238	\$32,239 - \$36,913
3	\$ 18,310	\$18,311 - \$22,888	\$22,889 - \$27,563	\$27,564 - \$32,238	\$32,239 - \$36,913	\$36,914 - \$41,588
4	\$ 22,050	\$22,051 - \$27,563	\$27,564 - \$32,238	\$32,239 - \$36,913	\$36,914 - \$41,588	\$41,589 - \$46,263
5	\$ 25,790	\$25,791 - \$32,238	\$32,239 - \$36,913	\$36,914 - \$41,588	\$41,589 - \$46,263	\$46,264 - \$50,938
6	\$ 29,530	\$29,531 - \$36,913	\$36,914 - \$41,588	\$41,589 - \$46,263	\$46,264 - \$50,938	\$50,939 - \$55,613

* Income verification may be requested and may include pay stubs or other documents containing income information for the appropriate time period (3 and 12 months prior to hospital services). Charity determination is based on income 6 months prior to the date of application.

****Add \$3,740.00 for each additional family member with more than 6 members**
Effective Discounts for Dates of Service after 1/23/09.**

Date of Application _____
 Patient Name _____
 Responsible Party, if not patient _____ Applicant Phone # _____
 Patient Date of Birth _____ Patient SS# (optional) _____
 Street Address _____
 City _____ State _____ Zip _____

Date(s) of hospital service: From _____ To _____

Are you an Ohio Resident at the time of your hospital services? Yes No

Were you an active Ohio Medicaid recipient at the time of your hospital services? Yes No

If yes, please provide Ohio Medicaid recipient ID Number _____

Were you an active recipient of Ohio Disability Assistance at the time of your hospital service? Yes No

If yes, please attach a copy of your OHIO DA effective during your hospital service to this application.

Did you have health insurance (other than medicare) at the time of your hospital service? Yes No

Please provide the following information for all of the people in your immediate family who live in your home. **“Family” is defined as the patient, the patient’s spouse, and all of the patient’s children under 18 (natural or adoptive) who live in the parent’s home.**

Name (Please include self)	Date of Birth	Relationship to Patient	Income for 3 mo prior to hospital service	Income for 12 mo prior to hospital service	Type of Income Verification*
(SELF)					

Please check here if your total checking and savings accounts balance is greater than \$10,000.

Total persons in family	Total family income 3 months	Total family income 12 months

If you report \$0 income provide a brief explanation of the following lines:

I had zero income from _____ to _____. My means of survival during this time was _____

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

Responsible Party/Patient Signature: _____ Date: _____