MERCER COUNTY JOINT TOWNSHIP COMMUNITY HOSPITAL

HCAP/FINANCIAL ASSISTANCE PROGRAM (FAP) APPLICATION

Form 332 01/2024

PATIENT NAME: ______________________________ Social Security #_____________ Date of Birth___________

Applicant Name, If not patient: ____________________ Relationship__________ Date of Application____________

To the best of my knowledge, I attest that the information I provided on this application is complete and accurate.

____ ___________________________

APPLICANT'S SIGNATURE **DATE**

(Please answer the following questions as they apply to the patient.)

STREET: ____CITY:_______________________________

STATE: ___________ ZIP CODE: ___________________ TELEPHONE #:________________________________

DATE(S) OF HOSPITAL SERVICE: ____

- Were you an Ohio resident at the time of hospital service? Yes____ No____ (**Must be Ohio resident to qualify**.)
- Please circle marital status at time of service: Married Single Widowed Divorced
  (If legally married, must include spouse's income even if living separately.)
- Do you have any health insurance? (example: Medicare, Commercial, Medicaid, Accident) Yes____ No____
  List name of health insurance carrier: ____
- When was the last time you applied for Ohio Medicaid assistance? ____________________ (if you qualify for free care you are required to have applied and been denied Medicaid assistance.)

List **all** members of patient's immediate family: patient's parent(s) (**if patient under 18**), patient's spouse (**if legally married at time service**), and all **natural or adopted** children **under the age of 18 (no step- or grand-children.)**

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

*Gross income verification **must be attached** for 13 weeks and/or 12 months **prior to** date of service. Gross income verification may include: copies of Paycheck Stubs, statement from employer, Income Tax Returns if self-employed, W-2's if services at end of year, or any other documents containing income information for the appropriate time period (rental property, Social Security income, child support, interest, profit/loss statement, etc.).

If you reported $0 income, please provide a brief explanation of how you (or the patient) are surviving financially.

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(DO NOT WRITE BELOW THIS LINE) Date Application received ___________________________

These guidelines below apply to services on or after 1/12/2024.

*Notwithstanding the sliding scale discounts, the amount due for eligible patients under Mercer Health FAP will not be more than the amount Mercer Health generally bills patients having traditional Medicare or private health insurance coverage for such care.

2024 FEDERAL POVERTY INCOME GUIDELINES (FR 1/12/2024)

Family Size	Free Care	50% Discount*	40% Discount*	30% Discount*	20% Discount*	10% Discount*
1	$15,060 or less	$15,061 - $18,072	$18,073 - $21,084	$21,085 - $24,096	$24,097 - $27,108	$27,109 - $30,120
2	$20,440 or less	$20,441 - $24,528	$24,529 - $28,616	$28,617 - $32,704	$32,705 - $36,792	$36,793 - $40,880
3	$25,820 or less	$25,821 - $30,984	$30,985 - $36,148	$36,149 - $41,312	$41,313 - $46,476	$46,477 - $51,640
4	$31,200 or less	$31,201 - $37,440	$37,441 - $43,680	$43,681 - $49,920	$49,921 - $56,160	$56,161 - $62,400
5	$36,580 or less	$36,581 - $43,896	$43,897 - $51,212	$51,213 - $58,528	$58,529 - $65,844	$65,845 - $73,160
6	$41,960 or less	$41,961 - $50,352	$50,353 - $58,744	$58,745 - $67,136	$67,137 - $75,528	$75,529 - $83,920

Add $5,380 for each additional person over six.

FAMILY SIZE ____________ GROSS INCOME (3 month/ 12 month): ______________________________________

APPROVED HCAP / APPROVED CHARITY CARE __________% DISCOUNT / DENIED -Letter Sent_____________________

REPRESENTATIVE______________________________ DATE______________ Date Range Approved _______________________