

**MERCER COUNTY JOINT TOWNSHIP COMMUNITY HOSPITAL
HCAP/FINANCIAL ASSISTANCE PROGRAM (FAP) APPLICATION**

Form 332 01/2026

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.

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

These guidelines below apply to services on or after 1/13/2026.

*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.

2026 FEDERAL POVERTY INCOME GUIDELINES (FR 1/15/2026)

Family Size	Free Care	50% Discount*	40% Discount*	30% Discount*	20% Discount*	10% Discount*
1	\$15,960 or less	\$15,961 - \$19,152	\$19,153 - \$22,344	\$22,345 - \$25,536	\$25,537 - \$28,728	\$28,729 - \$31,920
2	\$21,640 or less	\$21,641 - \$25,968	\$25,969 - \$30,296	\$30,297 - \$34,624	\$34,625 - \$38,952	\$38,953 - \$43,280
3	\$27,320 or less	\$27,321 - \$32,784	\$32,785 - \$38,248	\$38,249 - \$43,712	\$43,713 - \$49,176	\$49,177 - \$54,640
4	\$33,000 or less	\$33,001 - \$39,600	\$39,601 - \$46,200	\$46,201 - \$52,800	\$52,801 - \$59,400	\$59,401 - \$66,000
5	\$38,680 or less	\$38,681 - \$46,416	\$46,417 - \$54,152	\$54,153 - \$61,888	\$61,889 - \$69,624	\$69,625 - \$77,360
6	\$44,360 or less	\$44,361 - \$53,232	\$53,233 - \$62,104	\$62,105 - \$70,976	\$70,977 - \$79,848	\$79,849 - \$88,720

Add \$5,680 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 _____