HIGHLAND
DISTRICT HOSPITAL

Highland District Hospital participates in the **HOSPITAL CARE ASSURANCE PROGRAM** which has been designed to provide **FREE BASIC MEDICALLY NECESSARY CARE** to eligible patients.

Any individual who is a resident of the State of Ohio, not a recipient of the Medicaid or Disability Assistance program, and whose income is at or below the Federal Poverty Guidelines, may be eligible for uncompensated care for services up to 3 years prior to application date.

Family Unit 01/20/2017	100% FPL HCAP
1	$12,060.00
2	$16,240.00
3	$20,420.00
4	$24,600.00
5	$28,780.00
6	$32,960.00
7	$37,140.00
8	$41,320.00

For additional family member add: $4,180.00

Highland District Hospital also has a financial assistance program for patients whose income may be over the Federal Poverty Guidelines and need assistance resolving their hospital bills.

This program may discount a percentage of the hospital bill, based on the households' income, up to and including 200% of the Federal Poverty Guideline.

If you believe you may be eligible for financial assistance, please complete the application on the reverse side and return it, along with your proof of income, to Patient Financial Services within five (5) days following your care. Written determination of your eligibility will be made following your request.

****Please be advised that your account will only be eligible for financial Assistance for a period of 1 year from the original date of service****

Please complete the following if you answered yes to questions 2, 3, or 4 on the previous side.

Medical Coverage:

Disability Assistance Number (Recipient number must be 12 digits) _____

Medicaid (Recipient number must be 12 digits) _____

Insurance Name _____

Insured _____

ID Number _____

Group/Policy Number _____

Phone Number _____

Employer _____

Please complete the application on the reverse side.

Patient Financial Services: (937) 840-6512

Application for Financial Assistance
(H.C.A.P OR F.A.P)

Patient name _____ Date of Application ____/____/____

Applicant Name, if not Patient: _____ Phone: _____
(If the applicant is not the patient, please answer the following questions as they apply to the patient)
Street: _____ MPI: _____
City: _____ State _____ Zip _____
Date(s) of Hospital Service: From _____ To _____ Account#: _____
At the time of service: Date of Service: _____

1. Were you a resident of Ohio? _____
2. Did you have Medicaid coverage? _____
3. Were you a recipient of Disability Assistance? _____
4. Were you covered by Insurance? _____

** If 'Yes' to question 2, 3, or 4, please complete the other side before continuing.

This application CANNOT be processed without an explanation of how you were supported financially.

Please Note: Highland District Hospital's Financial Assistance Programs do NOT cover Physician fees.

List **ALL** in Family Name	Date Of Birth	Relation to Patient	ALL Family GROSS Income		Type of income verification attached.**
			3 months **BEFORE** Date of Service.*	12 months **BEFORE** Date of Service.*	

A family shall include patent(s), their spouse, all children (natural or adoptive), under 18, living at home.

*Highland District Hospital reserves the right to request income verification before making a determination of eligibility. If you report $0.00 income, you must provide an explanation of how you were being supported.

** Income information may include pay stubs, letter from employer, other documents containing income information for the Period of 3 to 12 months **PRIOR TO** the date of service.

A Self-Employed, Business or Farming Tax Return, for the year PRIOR to the year of service, and an income statement for the 3 months prior to the date of service are required. Regular Tax Returns are only acceptable as a last resort.

Certification:
I understand that this information is subject to confirmation by Highland District Hospital. I also understand that if the information I submit is determined to be false, my application will be denied and I will be liable for payment of services provided.

Date: _____ Signature: _____

HOSPITAL USE ONLY	Orig. T/C: _____	T/C W/O: _____	T/C Due: _____
HCAP ELIG _____	Orig. P/C: _____	P/C W/O: _____	P/C Due: _____
FAP ELIG _____%	**Totals: _____**	**W/O: _____**	**Due: _____**

Person making determination: _____ ____ W/O Sheet; ____ Mssge Log; ____ PCB; ____ MBA; ____ <BD>; ____ Letter

C PRG 1600b (3/17)