FINANCIAL ASSISTANCE SCREENING APPLICATION

Hospital Care Assurance Program (HCAP)
Contact Information: 740-687-8025

401 N. Ewing Street
Lancaster, OH 43130

Patient Name _____ Marital Status _____

Complete Address _____ Home Phone # _____

_____ Cell Phone # _____

Social Security # ___ ___ ___ – ___ ___ – ___ ___ ___ ___ Account # _____

Date(s) of Service _____ Date of Birth _____

	Circle One		Circle One
Are you a resident of Ohio?	YES NO	Were you eligible for Medicaid or Medicaid Managed Care on this date of service?	YES NO
Is anyone else being held financially reponsible for the services provided? **If Yes,** Name _____ Contact # _____	YES NO	Did you have any other insurance coverage for this date of service? If Yes, please provide the name of "other insurance coverage". _____	

For purposes of HCAP "family" is defined as the patient, the patient's spouse and all of the patient's children under 18 (natural or adopted) who live in the patient's home. Please list all applicable family below:

Name	Age	Reside in home (circle one)	Relationship To Patient
		YES NO	
		YES NO	
		YES NO	
		YES NO	
		YES NO	
		YES NO	
		YES NO	
		YES NO	
		YES NO	

If the patient is a minor, please provide both the mother and the father's income.

Your Statement of Gross Income (BEFORE TAXES) Please indicate income in the fields provided	**Patient/Mother**	**Spouse/Father**
3 months prior to date of service **TOTAL** income.	$	$
12 months prior to date of service **TOTAL** income.	$	$

If reported income is "$0" please provide a brief statement to explain how your normal living expenses are provided for.

_____

_____

_____

PROOF OF RESIDENCY MUST BE ATTACHED AND SENT WITH THIS APPLICATION

Please check proof of residency attached: _____Copy of driver's license _____Voter's registration card

_____Copy of canceled mail _____Other

I attest that the above information is true and correct to the best of my knowledge and is subject to confirmation by Fairfield Medical Center. I understand that I may be asked for documented proof of income for this application. I also understand that if the information is determined to be false, I will be liable for payment of services.

_____ _____

Signature - Please Use Black or Blue Ink Only Date

FAIRFIELD MEDICAL CENTER

Lancaster, Ohio

NOTICE OF AVAILABILITY FOR UNCOMPENSATED SERVICES

Fairfield Medical Center is required by law to give a reasonable amount of its service without charge to eligible persons who cannot afford to pay for care.

To be eligible to receive uncompensated care your family income must be at or below the following levels.

SIZE OF FAMILY	POVERTY GUIDELINES WITHOUT CHARGE	POVERTY GUIDELINES AT REDUCED CHARGE
1	$12,060	$ 36,180
2	16,240	48,720
3	20,420	61,260
4	24,600	73,800
5	28,780	86,340
6	32,960	98,880
7	37,140	111,420
8	41,320	123,960
For each Additional Family Member Add:	$ 4,180	$ 12,540

FAIRFIELD MEDICAL CENTER
SLIDING SCALE CALCULATION
Effective January 26, 2017

Family Size	100% Discount		75% Discount		50% Discount		25% Discount	
	Greater Than	Up To	Greater Than	Up To	Greater Than	Up To	Greater Than	Up To
	*FPL**	*200%*	*200%*	*250%*	*250%*	*275%*	*275%*	*300%*
1	$12,060	$24,120	$24,120	$30,150	$30,150	$33,165	$33,165	$36,180
2	$16,240	$32,480	$32,480	$40,600	$40,600	$44,660	$44,660	$48,720
3	$20,420	$40,840	$40,840	$51,050	$51,050	$56,155	$56,155	$61,260
4	$24,600	$49,200	$49,200	$61,500	$61,500	$67,650	$67,650	$73,800
5	$28,780	$57,560	$57,560	$71,950	$71,950	$79,145	$79,145	$86,340
6	$32,960	$65,920	$65,920	$82,400	$82,400	$90,640	$90,640	$98,880
7	$37,140	$74,280	$74,280	$92,850	$92,850	$102,135	$102,135	$111,420
8	$41,320	$82,640	$82,640	$103,300	$103,300	$113,630	$113,630	$123,960

Patient Share	0%	25%	50%	75%
FMC Adjustment	100%	75%	50%	25%