

## FCHC Medical Care

Thank you for choosing FCHC Medical Care for your healthcare needs.

Included is an application for Financial Assistance for services rendered at FCHC Medical Care, Fulton County OB/GYN, Delta Medical Center, Fayette Medical Center, West Ohio Family Physicians, West Ohio Orthopedics and West Ohio Pediatrics.

Please be aware that Financial Counselor(s) may request below information in order to process your financial application to best benefit you.

### **Required for Processing:**

- ALL questions must be answered
- List all family members, ages, and relationship to patient living in household
- All INCOME lines must be completed (Include 3 months/12 months)
- IF ZERO INCOME is reported you MUST include a statement of how you are financially surviving
- The application must be **SIGNED and DATED**

### **Additional Request:** (may be requested for additional financial programs)

- Applied for Medicaid – If monthly spenddown, list amount \$\_\_\_\_\_
- Copies of current income and previous year taxes
- Attach current copies of all medical bills (Medical, Prescriptions, Dental and Vision)
- Debt to Income

Your prompt response in completing and returning your financial application will help avoid future billings and/or potential collection activity.

Please call the Financial Counseling Office with any questions, to set up an appointment or for assistance in completing your application. We can be reached Monday - Wednesday (8am to 5pm) Thursday & Friday (8am to 4:30pm) by contacting us at **419-330-2669 (option # 7)**.

You may send your completed application to FCHC by: fax- 419-330-2686, email – [cashiers@fulhealth.org](mailto:cashiers@fulhealth.org) or mail to:

FCHC Medical Care  
Attn: Financial Counseling  
735 South Shoop Avenue  
Wauseon, Ohio 43567

Effective 01/25/16

**2015 INCOME GUIDELINES**

**2016 INCOME GUIDELINES**

<b>FAMILY SIZE</b>	<b>HCAP</b>	<b>CHARITY</b>	<b>FAMILY SIZE</b>	<b>HCAP</b>	<b>CHARITY</b>
1	12,060	24,120	1	11,880	23,760
2	16,240	32,480	2	16,020	32,040
3	20,420	40,840	3	20,160	40,320
4	24,600	49,200	4	24,300	48,600
5	28,780	57,560	5	28,440	56,880
6	32,960	65,920	6	32,580	65,160
7	36,140	72,280	7	36,730	73,460
8	40,320	80,640	8	40,890	81,780

DOS 1/22/2015 - 1/24/2016

Add \$4,160 for each additional person if the family unit has more than eight members.

DOS 1/25/2016 - Present

Add \$4,160 for each additional person if the family unit has more than eight members.

FCHC MEDICAL CARE  
ATTN: FINANCIAL COUNSELING  
735 SOUTH SHOOP AVENUE  
WAUSEON, OH 43567  
**419-330-2669**

OFFICE HOURS: Monday –Wednesday 8:00 A.M. – 5:00 P.M.  
Thursday – Friday 8:00 A.M. – 4:30 P.M.

## APPLICATION FOR HCAP / FINANCIAL ASSISTANCE PROGRAMS

Patient Name:		Date:																																	
Guarantor Name:		Phone #:																																	
Street Address:		Contact#:																																	
City / State / Zip:		Email Addr:																																	
Were you an <b>active recipient of Disability Assistance</b> at the time of your service? <i>If you answered Yes, please attach a copy of your DA card to this application</i>			<b>Yes</b>																																
Were you an <b>active Medicaid recipient</b> at the time of your hospital service? <i>If Yes, enter Medicaid recipient ID number _____</i>			<b>No</b>																																
Did you have health insurance (other than Medicaid) at the time of your service? <i>If Yes: Insurance Name: _____ Policy Holder: _____ Policy# _____</i>																																			
<p>1. Please provide the following information for all of the people in your immediate family who live in your home. 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 adoptive) who live in the patient's home. If the patient is under the age of 18, the Family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s)' children under 18 (natural or adoptive) who live in the patient's home.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Name</th> <th style="width: 25%;">Social Security #</th> <th style="width: 15%;">Age</th> <th style="width: 35%;">Relationship to Patient</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3"></td> <td style="text-align: right;">Total persons in family</td> </tr> </tbody> </table>				Name	Social Security #	Age	Relationship to Patient																												Total persons in family
Name	Social Security #	Age	Relationship to Patient																																
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2. Total family GROSS income for <b>the previous</b> 3 months (required):	\$ _____	\$ _____	\$ _____ TOTAL: \$ _____																																
3. Total family GROSS income for <b>the previous</b> 12 months (required):	\$ _____	thru _____	TOTAL Income: \$ _____																																
4. Current family gross income for ----->	Week: \$ _____	Month: \$ _____	Annual: \$ _____																																
<p>Required:  <b>If you are reporting a \$0 income, please provide a brief explanation of how you or the patient is surviving financially.</b></p> <p>_____</p> <p>_____</p> <p>_____</p>																																			
<p>By my signature below, I certify that everything I have stated on this application and on any attachments is correct.</p> <p>X _____ Date: _____</p> <p style="text-align: center;">(Applicant Signature)</p>																																			

HCAP \_\_\_\_\_ Financial Assistance \_\_\_\_\_

Date Received: \_\_\_\_\_ by \_\_\_\_\_

For Office Use  
only

Patient Name: \_\_\_\_\_

**Visits:**

Account #	Date of Service	Account #	Date of Service
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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Please return this application to:

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