MERCER COUNTY JOINT TOWNSHIP COMMUNITY HOSPITAL

HCAP/FINANCIAL ASSISTANCE PROGRAM (FAP) APPLICATION

Form 332 02/20

PATIENT NAME: _____DATE of APPLICATION_____

Applicant Name, If not patient: _____ Patient Social Security #:_____
(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**.)
- Do you have any health insurance? (example: Medicare, Commercial, Medicaid, Accident) Yes____ No____
  List name of health insurance carrier:_____

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** to this application for the amounts for the time periods listed above. 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.

_____

_____

_____

_____

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

_____ _____

DATE **APPLICANT'S SIGNATURE**

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

These guidelines below apply to services on or after 1/17/2020.

*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.

2020 FEDERAL POVERTY INCOME GUIDELINES (FR 1/17/2020)

Family Size	Free Care	50% Discount*	40% Discount*	30% Discount*	20% Discount*	10% Discount*
1	$12,760 or less	$12,761 - $15,312	$15,313 - $17,864	$17,865 - $20,416	$20,417 - $22,968	$22,969 - $25,520
2	$17,240 or less	$17,241 - $20,688	$20,689 - $24,136	$24,137 - $27,584	$27,585 - $31,032	$31,033 - $34,480
3	$21,720 or less	$21,721 - $26,064	$26,065 - $30,408	$30,409 - $34,752	$34,753 - $39,096	$39,097 - $43,440
4	$26,200 or less	$26,201 - $31,440	$31,441 - $36,680	$36,681 - $41,920	$41,921 - $47,160	$47,161 - $52,400
5	$30,680 or less	$30,681 - $36,816	$36,817 - $42,952	$42,953 - $49,088	$49,089 - $55,224	$55,225 - $61,360
6	$35,160 or less	$35,161 - $42,192	$42,193 - $49,224	$49,225 - $56,256	$56,257 - $63,288	$63,289 - $70,320
7	$39,640 or less	$39,641 - $47,568	$47,569 - $55,496	$55,497 - $63,424	$63,425 - $71,352	$71,353 - $79,280

Add $4,480 for each additional person over seven.

FAMILY SIZE _____ GROSS INCOME (3 month/ 12 month): _____

APPROVED HCAP / APPROVED CHARITY CARE _____% DISCOUNT / DENIED -Letter Sent_____

REPRESENTATIVE_____ DATE_____ Date Range Approved _____