

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

Form 332 02/2022

PATIENT NAME: \_\_\_\_\_ DATE of APPLICATION \_\_\_\_\_

Applicant Name, If not patient: \_\_\_\_\_ Patient Social Security #: \_\_\_\_\_

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.**)
- ✍ 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	\$	\$
			\$	\$
			\$	\$
			\$	\$
			\$	\$
			\$	\$
<b>Total persons in family</b>		<b>Total Gross Family Income</b>	\$	\$

\***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 1/12/2022.**

\*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.

**2022 FEDERAL POVERTY INCOME GUIDELINES (FR 1/12/2022)**

Family Size	Free Care	50% Discount*	40% Discount*	30% Discount*	20% Discount*	10% Discount*
<b>1</b>	\$13,590 or less	\$13,591 - \$16,308	\$16,309 - \$19,026	\$19,027 - \$21,744	\$21,745 - \$24,462	\$24,463 - \$27,180
<b>2</b>	\$18,310 or less	\$18,311 - \$21,972	\$21,973 - \$25,634	\$25,635 - \$29,296	\$29,297 - \$32,958	\$32,959 - \$36,620
<b>3</b>	\$23,030 or less	\$23,031 - \$27,636	\$27,637 - \$32,242	\$32,243 - \$36,848	\$36,849 - \$41,454	\$41,455 - \$46,060
<b>4</b>	\$27,750 or less	\$27,751 - \$33,300	\$33,301 - \$38,850	\$38,851 - \$44,400	\$44,401 - \$49,950	\$49,951 - \$55,500
<b>5</b>	\$32,470 or less	\$32,471 - \$38,964	\$38,965 - \$45,458	\$45,459 - \$51,952	\$51,953 - \$58,446	\$58,447 - \$64,940
<b>6</b>	\$37,190 or less	\$37,191 - \$44,628	\$44,629 - \$52,066	\$52,067 - \$59,504	\$59,505 - \$66,942	\$66,943 - \$74,380

Add \$4,720 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 \_\_\_\_\_