

Hospital    Physician

**INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED**

**Check office you are visiting:**    Aultman Hospitalists    Maternal Fetal Medicine    Pathology    Surgical Associates    Aultman Physician Center    Dr. Tabet, Dr. Weiner or Dr. Immesoete    Cardiovascular Consultants    Canton General Surgery    Anesthesia/Pain Management  
 Canton Urology    Dr. Michael Hopkins

PATIENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN (optional): \_\_\_\_\_

APPLICANT NAME (if not a patient): \_\_\_\_\_

(If the applicant is not the patient, please answer the following questions as they apply to the patient.)

STREET: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

The following questions must be answered in order to process your application:

1. Were you an Ohio resident at the time of your hospital service?    Yes    No
2. Were you an active Medicaid/DMA recipient at the time of your service?    Yes    No  
 If yes, Medicaid recipient ID number: \_\_\_\_\_
3. Did you have health insurance (other than Medicaid) at the time of your hospital service?    Yes    No
4.  Single    Married    Separated (if separated, spouse's income is still required.)

 **Check if you are self employed and include your 1040 and appropriate schedule.**

Family members include you, your spouse, and/or natural or adopted children under the age of 18 living in the home. For patients under the age of 18, list the patient, the patient's natural or adoptive parent(s) (regardless of whether the parent lives in the home with the patient or not), and the patient's siblings (natural or adoptive) who live in the home.

OFFICE USE ONLY	
State of Ohio HCAP Approved	<input type="checkbox"/> YES <input type="checkbox"/> NO
HCAP Eligibility Dates:	
from _____	to _____
Aultman FAP Approved	<input type="checkbox"/> YES <input type="checkbox"/> NO
Aultman Physician FAP Approved	<input type="checkbox"/> YES <input type="checkbox"/> NO
FAP Discount _____%	
Expires _____	

NAME (First, Last)	AGE	RELATIONSHIP TO PATIENT	Earned and/or Unearned Income	Frequency Weekly/every 2 weeks/monthly	Type of Income	Total Gross Income* for 3 months prior to service date <small>*Prior to Deductions</small>	Total Gross Income* for 12 months prior to service date <small>*Prior to Deductions</small>
Jane Doe (example)	43	Self	\$200.00	Weekly	Unemployment	\$2,400.00	\$9,600.00
(Patient)							
Total Family Size:					Total income:		

NOTE: If you or any family member have no income, you must state "0".

**If you reported zero "0" income,** please explain below how basic food and housing needs were provided prior to the date of service:

 \_\_\_\_\_  
 \_\_\_\_\_

By my signature below, I affirm that to the best of my knowledge the answers on this application are true. In order to support you, Aultman may use third party organizations to verify the financial information stated on this application.

Date: \_\_\_\_\_ Applicant Signature: \_\_\_\_\_

**Office Use Only**   Date: \_\_\_\_\_ Signed: \_\_\_\_\_ Outreach Representative

## COMPLETING THE APPLICATION

In order to determine eligibility for HCAP or Financial Assistance, we look at your gross income and family size as outlined OAC 5101:3-1-07.17

### Eligibility for HCAP:

1. You must be a resident of the state of Ohio.
2. You must be at or below 100% of the Federal Poverty Income Guidelines.
3. Family members include you, your spouse, and/or natural or adopted children under the age of 18 living at home.
4. Cannot be enrolled in Medicaid.

### Eligibility for FAP:

1. You must be between 101%-400% of the Federal Poverty Guidelines.
2. You must not have ANY type of insurance coverage (i.e. Medicare, Medicaid or commercial insurance).
3. Family members include you, your spouse, and /or natural or adopted children under the age of 18 living at home.

If you have any questions please contact our office:

330-363-2200

If you receive medical services at Aultman or are seen by any Aultman employed physician and feel you qualify to receive these services without cost or at a reduced cost to you, please complete this application and return to:

Aultman Patient Outreach  
2600 Sixth St SW  
Canton OH 44710

**This program only covers services billed by Aultman.**

These financial assistance programs do NOT cover expenses for your non-Aultman providers (including but not limited to emergency room physician and radiologist).

**IMPORTANT:** In order to provide you with help under Aultman Financial Assistance, you are required to cooperate completely with our Financial Counselors in order to determine eligibility for medical coverage from the State.

**NOTE:** The HCAP program does not cover elective or cosmetic surgery, organ transplants, patient convenience items, take home pharmacy, physician and anesthesia charges.

**Incomplete applications will not be considered for financial assistance.**



## Financial Assistance Programs

Under the Ohio Hospital Care Assurance Program (**HCAP**), Aultman offers basic, medically necessary hospital-level services free of charge to individuals who are residents of Ohio and whose income is at or below the Federal Poverty Income Guidelines.

In addition to the HCAP program, Aultman provides financial assistance (**FAP**) on a sliding scale to patients who do not have insurance at family income levels up to four (4) times the Federal Poverty Guidelines.

### Guidelines for FREE Care

Family Size	Income 2011	Income 2012
1	\$10,890	\$11,170
2	\$14,710	\$15,130
3	\$18,530	\$19,090
4	\$22,350	\$23,050
5	\$26,170	\$27,010
6	\$29,990	\$30,970
7	\$33,810	\$34,930
8	\$37,630	\$38,890

For each additional family member add \$3820 for 2011 and \$3960 for 2012.