Fisher Titus Health Care Assurance and Financial Assistance Application

Ohio residents that have income at or below poverty income guidelines or who have other third-party coverage may qualify for “basic medically necessary” services under Ohio’s Provision of Free Care ruling. Basic medically necessary hospital-level services are defined as all inpatient and outpatient services covered by Medicaid apart from transplants and services associated with them.

Applicant’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Applicant’s Signature **(REQUIRED)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*BY MY SIGNATURE ABOVE, I CERTIFY EVERYTHING I HAVE STATED ON THE APPLICATION AND ATTACHMENTS ARE TRUE\*\***

SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status \_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date: \_\_\_\_\_\_\_\_\_\_ If Unemployed, How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_

SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Start Date: \_\_\_\_\_\_\_\_\_\_\_\_ If Unemployed, How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **For Office Use Only! F.A.**

**Did you have Health Insurance at the time of hospital service?** Yes, No 100% FTMC, B.H.  50% LLC

**Did you have Disability Asst. at the time of your hospital service?** Yes, No  75% FTMC, B.H.  20% NCEMS

**Did you have Active Medicaid Ins. at the time of your hospital service?** Yes, No  20% FTMC, B.H.

 **\*\*If yes, Medicaid ID number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APPROVED BY: DATE:

 **Were you an Ohio resident at the time of your hospital service?** Yes, No

EFFECTIVE DATES:

**THIS APPLICATION MAY TAKE UP TO 45 DAYS TO PROCESS**

**\*\*\*IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS PLEASE ATTACH A COPY OF YOUR INSURANCE OR MEDICAID CARD.\*\*\***

**Asset Assessment: Do you own or have any of the following?** Home? Yes, No Mort. Pmt. $\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Rent Pmt. $\_\_\_\_\_\_\_\_\_

Life Ins. Policy? Yes, No If yes, value? $\_\_\_\_\_\_\_ Own a Vehicle? Yes, No If yes, year, make, and model: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Checking Acct? Yes, No If yes: $\_\_\_\_\_\_\_\_\_\_\_ Savings Acct? Yes, No If yes, $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any stocks, bonds, CDs, rental property, or recreational vehicles? Yes, No If yes, what and value: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOTAL MEMBERS IN FAMILY \_\_\_\_\_\_\_\_ TOTAL FAMILY INCOME $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\*Income verification MUST be attached and should include: Current W2’s, 2 Current paystubs, Current S.S. Benefits Letter, Pension/401K, Unemployment Stmt. Etc. Current 1-month Bank Statement is required. As part of verification, Fisher Titus may reference third-party data sources to verify information. Including, but not limited to, obtaining consumer credit profile.**

\*\***If you reported NO income for the past 3 months, you MUST provide a brief explanation of how you are being supported financially**\*\*

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name\*** | **Date of Birth\***  | **Relationship to patient\*** | **Income 3 months prior to service** | **Income 12 months prior to service** | **Type of Income verification attached.** |
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**Please provide the following information for all members of your immediate family who live in your home. For purposes of HCAP “family is defined as the patient, patient’s spouse, and children under 18 who live in the patient’s home.” (Legal Guardians MUST provide proof of Custody)**

  **2022 FPL INCOME GUIDELINES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Person(s) in family/household | 0%-100% FPL**HCAP** | 101%-150% FPL**FREE CARE DISCOUNT** | 151%-200% FPL**75% DISCOUNT** | 201%-300% FPL**54% DISCOUNT** |
| 1 | $13,590 | $13,591 | To | $20,385 | $20,386 | To  | $27,180 | $27,181 | To  | $40,770 |
| 2 | $18,310 | $18,311 | To | $27,465 | $27,466 | To | $36,620 | $36,621 | To | $54,930 |
| 3 | $23,030 | $23,031 | To | $34,545 | $34,546 | To | $46,060 | $46,061 | To | $69,090 |
| 4 | $27,750 |  $27,751 | To | $41,265 | $41,266 | To | $55,500 | $55,501 | To | $83,250 |
| 5 | $32,470 | $32,471 | To | $48,705 | $48,706 | To | $64,940 | $64,941 | To | $97,410 |
| 6 | $37,190 | $37,191 | To | $55,785 | $55,786 | To | $74,380 | $74,381 | To | $111,570 |
| 7 | $41,910 | $41,911 | To | $62,865 | $62,866 | To | $83,820 | $83,821 | To | $125,730 |
| 8 | $46,630 | $46,631 | To | $69,945 | $69,946 | To | $93,260 | $93,261 | To | $139,890 |

\*\*\*For families/households with more than 8 persons, add $4,720 for each additional person.

\*\*\*This table shall be adjusted in accordance with annually released changes to the Federal Poverty Level (FPL). Revised 02/21/2022