

**MERCER COUNTY JOINT TOWNSHIP COMMUNITY HOSPITAL
HCAP/CHARITY CARE APPLICATION FOR ASSISTANCE**

Form 332

01/08

PATIENT NAME: _____ DATE of APPLICATION _____

APPLICANT NAME (IF NOT PATIENT): _____
(Please answer the following questions as they apply to the patient.)

STREET: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE#: _____

DATE(S) OF HOSPITAL SERVICE: _____

✍ Last Date of applying for Medicaid Assistance. _____ (Prefer within last 4 months)

✍ 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 including Medicaid? Yes ___ No ___
List: _____

✍ Were you an active recipient of ODJFS Disability Assistance at the time of hospital service? Yes ___ No ___ (Please attach card copy)

List **all** members of patient's immediate family: patient's parent(s) (if patient under 18), patient's spouse, and all **natural or adoptive children under the age of 18.**

Name	Age	Relationship to Patient	Income for 3 months prior to hospital service*	Income for 12 months prior to hospital service*	Type of income verification attached **
(patient)		Self	\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	
Total persons in family		Total Family Income	\$	\$	

*Income verification must be attached to this application for amounts listed.

**Income verification may include: Copies of Paycheck Stubs, statement from employer, Income Tax Returns, W-2's, or any other documents containing income information for the appropriate time period (rental property, public assistance, child support, compensation, interest, 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

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(DO NOT WRITE BELOW THIS LINE - Office Use Only)

Date Application received _____

***Free Care policy applies for all dates of services. **Discount rates apply to dates of services after October 1, 2004 only.
2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FEDERAL POVERTY GUIDELINES (FR 1/23/2008)**

Family Size	Free Care*	50% Discount **	40% Discount**	30% Discount**	20% Discount**	10 % Discount**
1	\$10,400 or less	\$10,401 - \$11,440	\$11,441 - \$12,480	\$12,481 - \$13,520	\$13,521 - \$14,560	\$14,561 - \$15,600
2	\$14,000 or less	\$14,001 - \$15,400	\$15,401 - \$16,800	\$16,801 - \$18,200	\$18,201 - \$19,600	\$19,601 - \$21,000
3	\$17,600 or less	\$17,601 - \$19,360	\$19,361 - \$21,120	\$21,121 - \$22,880	\$22,881 - \$24,640	\$24,641 - \$26,400
4	\$21,200 or less	\$21,201 - \$23,320	\$23,321 - \$25,440	\$25,441 - \$27,560	\$27,561 - \$29,680	\$29,681 - \$31,800
5	\$24,800 or less	\$24,801 - \$27,280	\$27,281 - \$29,760	\$29,761 - \$32,240	\$32,241 - \$34,720	\$34,721 - \$37,200
6	\$28,400 or less	\$28,401 - \$31,240	\$31,241 - \$34,080	\$34,081 - \$36,920	\$36,921 - \$39,760	\$39,761 - \$42,600
7	\$32,000 or less	\$32,001 - \$35,200	\$35,201 - \$38,400	\$38,401 - \$41,600	\$41,601 - \$44,800	\$44,801 - \$48,000

Add \$3,600 for each additional person over seven.

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

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

REPRESENTATIVE _____ DATE _____