LICKING MEMORIAL HEALTH SYSTEMS

Enclosed is an Financial Assistance application. This application is used for the Hospital Care Assurance Program and the Community Assistance Program.

For hospital based services, the following provider types are covered by this program: Pathology, Emergency Room, Anesthesia, and Inpatient Hospitalists. Radiology services are provided by Tri County Radiologists. Radiology services will be billed independently and are not included in this program.

Please return the completed application within 10 days to:

Licking Memorial Hospital
Attn: Cashier Office
1320 West Main Street
Newark, Ohio 43055

If you have any questions or need assistance in completing the application, please call the Patient Accounting Department at 220-564-4500 from 7:30 a.m. - 5:00 p.m., Monday through Friday.

INCOME :
You must provide the amount of your family's **total gross income** for the three months and twelve months immediately preceding the date(s)-of-service for which you are requesting assistance. This must include income for the patient and the patient's spouse (regardless of whether they live in the home) and all of the patient's children, natural or adoptive, under the age of 18 who live in the home. Write the total gross income in the space provided on the application. Additional documentation of income is not required to be returned with the application. However, you are responsible to maintain supporting documentation of the income reported. In the event of an audit, you will be required to produce acceptable income documentation.

Examples of acceptable income verification include:

- Check stubs for the 3 and 12 months preceding your date-of-service.
- Documentation of Social Security, unemployment compensation, alimony, child support or pensions.
  If you do not have documentation to support these income sources, you should contact the issuing office to request a statement of income for the appropriate time period. If an employer's statement of gross income is used, it must be signed and dated by the employer and must be printed on company letterhead.
  Self-employed applicants must provide gross income, less reasonable business expenses. Personal expenses are not permitted. In the event of an audit, acceptable income verification includes Tax schedule C.
- If you earned $0 income for the three months or twelve months prior to your date(s)-of-service, provide a brief explanation on the back of the application or on an attached sheet. Your explanation must include the beginning and ending dates of the period in which your family earned $0 income (3 or 12 months prior to the services for which you are applying for assistance).

FAMILY:
For the Hospital Care Assurance Program and the Community Assistance Program "family" is defined as the patient, the patient's spouse (regardless of whether they live in the home), and all of the patient's children under the age of 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the "family" includes the patient, the patient's natural or adoptive parent(s) (regardless of whether they live in the home), and the patient(s)' children, natural or adoptive under the age of 18 who live in the home.

To be eligible for the Hospital Care Assurance Program:

- You must be an Ohio resident.
- Your household income must be at or below the federal poverty income guidelines.

To be eligible for the Community Assistance Program:

- You must be a Licking County resident.
- Your household income must not exceed 250% of the federal poverty income guidelines.

LICKING MEMORIAL HEALTH SYSTEMS
FINANCIAL ASSISTANCE APPLICATION

For hospital based services, the following provider types are covered by this application: Pathology, Emergency Room, Anesthesia, and Inpatient Hospitalists. Radiology services are provided by Tri County Radiologists. Radiology services will be billed independently and are not included in this program.

Patient Name: _____ Date of Application: _____

Applicant Name, if not the patient: _____

Please answer the following questions as they apply to the patient: Social Security Number: _____

Street: _____ County: _____

City/State: _____ Zip: _____ Telephone: _____

Date of Service: From _____

- Were you an Ohio resident at the time these services were rendered? Yes _____ No _____
- Were you an active Medicaid recipient at the time these services were rendered? Yes _____ No _____
  If yes, provide Medicaid recipient ID number: _____
- Were you an active recipient of Disability Assistance at the time these services were rendered? Yes _____ No _____
  (If yes, please attach a copy of your DA card effective on the dates of service for this application.)
- Did you have health insurance (other than Medicaid) at the time these services were rendered? Yes _____ No _____

Please provide the following information for all of the members of your family. For these purposes, "family" is defined as the patient, the patient's spouse (regardless of whether they live in the home), and all of the patient's children under the age of 18 (natural or adoptive) who live in the patient's home**.** If the patient is under the age of 18, see a more detailed definition of family on the instruction sheet. **Provide gross family income for the 3 months prior and 12 months prior to the date(s) of service.**

Name	Birthdate	Relationship **to patient**	Gross Income for 3 months prior to **date(s) of service***	**Gross Income for 12 months prior to date(s) of service***
(Patient)		Self	$	$
			$	$
			$	$
			$	$
			$	$
Total persons in family:		**Total family income:**	**$**	**$**

*Eligibility is based upon **gross income**. If you reported $0 income, provide a brief explanation on the back of this form or on an attached sheet. Your explanation should include the beginning and ending dates of the period in which your family earned $0 income. (3 and 12 months prior to the services for which you are applying for assistance)

By my signature below, I certify that everything I have stated on this application and on any attachments is true.

Signature of applicant **Date**

ELIGIBILITY DETERMINATION (*For office use only)*

The applicant is approved: ____ HCAP _____% Community Service Assistance for IP/OP services. (Circle applicable types(s) of service.) Determination is valid for outpatient services through: _____. Each inpatient admission requires a new application.

The applicant is denied: *Reason(s)* _____

Applicant notified on: _____

Approved by: _____ Date: _____

1900-0003
3/12/13, 3/1/16

VOUCHER OF UNEMPLOYMENT AND/OR ZERO INCOME FOR FINANCIAL ASSISTANCE APPLICATION

I, _____ have not been employed and I

have received no income from _____/_____/_____ to _____/_____/_____.
(mm/ dd / yy) *(mm / dd / yy)*

I did not collect unemployment compensation during this period.

Following is an explanation of how I pay for my living expenses (rent, utilities, food, etc.). Do not list your bills. *This information is required.*

_____

_____

_____

_____

_____

Signature: _____

Date: _____

1900-0003
3/12/13, 3/1/16