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# ADENA HEALTH SYSTEM

# PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY (FAP)

Adena Health System recognizes that some people cannot pay for all or part of their healthcare service. We are committed to providing access to healthcare to all persons, regardless of the ability to pay. We will do this in a compassionate manner that respects each person’s dignity and privacy.

## FINANCIAL ASSISTANCE PROGRAM

Patients must use all other resources, including application to the local Department of Job and Family Services, before financial assistance will be considered. Eligibility for assistance is based upon total gross income (how much you make before taxes) and the number of dependents (usually children but sometimes relatives who live with you) in your family. People who have special circumstances may receive further consideration. Eligible patients will not be charged more than patients who have insurance

## HOW TO APPLY FOR FINANCIAL ASSISTANCE

#### Call 855-275-7408

An application is printed on the back side of your billing statement

**For a free copy of the FAP and the application in English or other languages talk to Adena representative or visit** [www.adena.org](http://www.adena.org)

**If you would like a copy of Adena’s Billing and Collection policy, please contact 855-275-7408 or visit** [**www.adena.org**](http://www.adena.org)

**What you need to apply:**

* 3 Months prior proof of income (pay stubs, social security income letter, etc)
* A bank statement
* An income less 400% of the federal poverty level
* You cannot be a recipient of Medicaid
* You must live in Adams, Athens, Clinton, Fayette, Gallia, Green, Highland, Hocking, Jackson, Madison, Pickaway, Pike, Ross, Scioto, or Vinton counties. (National Health Service Corp. is an exception, see policy for full details.)

If you live another county or state, you must be

preapproved for financial assistance ***before receiving care*.**

These services **are** covered: necessary health care, including physician fees provided by Adena-employed physicians.

## HOSPITAL CARE ASSURANCE PROGRAM (HCAP)

If you meet the above requirements and your income is below 100% of the federal poverty line, you may also receive Assistance (called HCAP) for your part of the hospital bill.

HCAP cannot provide assistance **for:** unnecessary services (i.e. Cosmetic), transportation fees, dental services.

# ADENA HEALTH SYSTEM Financial Assistance Application



Patient or Applicant Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Of Service**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, etc.**

**Family members include all immediate family who reside in the home (to include spouse and/or natural or adopted children under 18 if applicable). Decisions will be rendered within 45 days of receipt of completed application.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family Member’s Name** | **Age** | **Date of Birth** | **Relationship**  **To Patient** | **Source of Income**  **or Employer Name** | **Income for 3 months**  **prior to date of service** | **Income for 12 months**  **prior to date of service** |
|  |  |  | **Patient** |  |  |  |
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|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

1) If you reported zero total income, how are you being supported? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Was the patient living in Ohio at the time of service? Yes\_\_\_\_ No\_\_\_\_

If you answered **yes** to question #3 please **attach a copy** of your insurance card.

3) Did the patient have Medical Insurance at the time of service? Yes\_\_\_\_ No\_\_\_\_

4) Does anyone in your home have checking/savings? Yes\_\_\_\_ No\_\_\_\_

**Certification:***By signing this document, I affirm the answers  on  this application  are true. Should a subsequent review of an individual’s  financial assistance  application reveal that  information  provided  by  the  individual  was  either incorrect  or  fraudulent, the  decision  to  provide  financial  assistance  may  be  reversed  and  the  responsible party  will  be  billed. I  understand  that  the  information  which I submit  is  subject  to  verification  by  my  hospital  provider, including  credit reporting agencies, and subject to review by federal and/or state agencies and others as required.*

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

Applicant’s signature

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

Date

**You MUST supply the following:**

* **3 months prior proof of income (pay stubs, social security income letter, self-employment statement, etc.)**
* **A bank statement within 3 months of date of service.**

**Return this form with**

**any attachments to:**

**Adena Health System**

**Financial Counselor**

**272 Hospital Rd Suite 240**

**Chillicothe, OH 45601**

**855-275-7408**

**Fax to: 740-779-8257**

# SELF EMPLOYMENT INCOME VERIFICATION

PLEASE NOTE: THIS FORM APPLIES ONLY IF YOU ARE SELF EMPLOYED

**MONTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR:\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

Gross Expenses Net

**MONTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR:\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

Gross Expenses Net

**MONTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR:\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

Gross Expenses Net

PLEASE LIST BUSINESS EXPENSES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_