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 740-779-8786

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

If you would like a copy of Adena's Billing and Collection policy please contact 740-779-4400 or visit 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, Fayette, Gallia, Highland, Hocking, Jackson, 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.

2019 POVERTY INCOME GUIDELINES

Family Size	Income < 100% FPL =100%	Income 101% to 200% FPL= 100%	Income 201% to 300% FPL= 60%	Income 301% to 400% FPL=60%
1	$12,490	$24,980	$37,470	$49,960
2	$16,910	$33,820	$50,730	$67,640
3	$21,330	$42,660	$63,990	$85,320
4	$25,750	$51,500	$77,250	$103,000
5	$30,170	$60,340	$90,510	$120,680
6	$34,590	$69,180	$103,770	$138,360
For each additional	$4,420	$8,840.00	$13,260	$17,680

person, add				

ADENA HEALTH SYSTEM HCAP and Financial Assistance Application

Patient Name:	Guarantor Name:
Social Security #:	Phone Number:
Address, City, State and **County (if a NHSC site county restrictions do not apply)**:	Hospital or Clinic Date(s) of Service:

1) Was the patient living in Ohio at the time of service? Yes____ No____
2) Did the patient have Medical Insurance at the time of service? Yes____ No____
3) Was the patient an active Medicaid recipient at the time of service? Yes____ No____
4) Was the patient an active recipient of Disability Assistance at the time of service? Yes____ No____

If you answered **yes** to question 3, 4, or 5 please **attach a copy** of your insurance, Medicaid, or DA card to this application.

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.

Family Member's Name	Age	Date of Birth	Relationship To Patient (please circle relationship)	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			

Please check income AND asset verification attached:
Copies of Pay Stubs Letter from employer
Unable to Provide Bank statement
P

If you reported $0 income, please provide a brief explanation of how you (or the patient) are surviving financially:

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

____
Applicant's signature

____
Date

Return this form with any attachments to:

Adena Health System
Financial Counselor
272 Hospital Rd Suite 240
Chillicothe, OH 45601
740-779-8786
Fax to: 740-779-8257

For office use only: Date App reviewed__________ **Application completed by**:____________
App Denied_____________App approved HCAP_______ 100%________ Partial_______
NHSC___________ Referred to MCD__________

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: _________________________________