FCHC Medical Care

Thank you for choosing Fulton County Health Center for your healthcare needs.

Enclosed is an application for Financial Assistance for services rendered at Fulton County Health Center, FCHC Medical Care, Fulton County OB/GYN, Delta Medical Center, Fayette Medical Center, West Ohio Family Physicians, West Ohio Orthopedics and West Ohio Pediatrics. ***Other providers who perform services at Fulton County Health Center, but are not covered under this policy include: Pathology (Dr Paneda), Radiology (Dr Pole), Emergency Room Physicians (ProBill – HLES), Anesthesia (NAP), and Wound Care (Dr Nazzal).*

Please be aware that Financial Counselor(s) may request below information in order to process your financial application to best benefit you.

"Effective 02/01/2017 – Applications cannot be processed for any co-pay portion. Any co-pay amount is patient responsibility."

Required for Processing:

- ALL questions must be answered.
- List all family members, ages, and relationship to patient living in household.
- All INCOME lines must be completed (Include 3 and/or 12 months) prior to the date of service.
- Do you have an HSA or FSA account? You must provide the most recent statement showing available balance.
- If you are a Michigan resident, please list the county you reside in _____.
- IF ZERO INCOME is reported you MUST include a statement of how you are financially surviving.
- The application must be **SIGNED and DATED BY THE PATIENT** unless the patient is a dependent.

Additional Request: (may be requested for additional financial programs)

- Applied for Medicaid.
- Copies of current income and previous year taxes.
- Attach current copies of all medical bills (Medical, Prescriptions, Dental and Vision).
- Debt to Income.

Your prompt response in completing and returning your financial application will help avoid future billings and/or potential collection activity.

Please call the Financial Counseling Office with any questions, to set up an appointment or for assistance in completing your application. We can be reached Monday - Wednesday (8am to 5pm) Thursday & Friday (8am to 4:30pm) by contacting us at **419-330-2669 (option # 7)**.

You may send your completed application to FCHC by: fax- 419-330-2686, email – cashiers@fulhealth.org or mail to:

FCHC Medical Care
735 South Shoop Avenue
Wauseon, Ohio 43567

Effective 01/13/18

2017 INCOME GUIDELINES

FAMILY SIZE	HCAP	CHARITY
1	12,060	24,120
2	16,240	32,480
3	20,420	40,840
4	24,600	49,200
5	28,780	57,560
6	32,960	65,920
7	37,140	74,280
8	41,320	82,640

DOS 1/31/2017 - 1/12/2018
Add $4,180 for each additional person if the family unit has more than eight members.

2018 INCOME GUIDELINES

FAMILY SIZE	HCAP	CHARITY
1	12,140	24,280
2	16,460	32,920
3	20,780	41,560
4	25,100	50,200
5	29,420	58,840
6	33,740	67,480
7	38,060	76,120
8	42,380	84,760

DOS 1/13/2018 - present
Add $4,320 for each additional person if the family unit has more than eight members.

FCHC MEDICAL CARE
ATTN: FINANCIAL COUNSELING
735 SOUTH SHOOP AVENUE
WAUSEON, OH 43567
419-330-2669

OFFICE HOURS: Monday –Wednesday 8:00 A.M. – 5:00 P.M.
Thursday – Friday 8:00 A.M. – 4:30 P.M.

APPLICATION FOR HCAP / FINANCIAL ASSISTANCE PROGRAMS

Patient Name:		Date:	
Guarantor Name:		Phone #:	
Street Address:		Contact#:	
City / State / Zip:		Email Addr:	

	Yes	No
Were you an **active recipient of Disability Assistance** at the time of your service? *If you answered **Yes** , please attach a copy of your DA card to this application*		
Were you an **active Medicaid recipient** at the time of your hospital service? *If **Yes,** enter **Medicaid recipient ID number*** _____		
Did you have health insurance (other than Medicaid) at the time of your service? *If Yes:* Insurance Name:_____Policy Holder:_____Policy#_____		

1. Please provide the following information for all of the people in your immediate family who live in your home. For purposes of HCAP, Family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the Family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s)' children under 18 (natural or adoptive) who live in the patient's home.

Name	Social Security #	Age	Relationship to Patient
			Total persons in family
2. Total family GROSS income for **the previous** 3 months (required):	$	$	$	TOTAL: $
3. Total family GROSS income for **the previous** 12 months (required):		thru		TOTAL Income: $
4. Current family gross income for ---------->	Week: $	Month: $		Annual: $

Required:
If you are reporting a $0 income, please provide a brief explanation of how you or the patient is surviving financially.

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

X_____ Date:_____
(Applicant Signature)

HCAP_____Financial Assistance_____ Date Received:_____by_____

For Office Use only

Patient Name: _____

Visits:

Account #	Date of Service	Account #	Date of Service

Please return this application to:

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WAUSEON, OH 43567
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