**Trinity Health System Financial Assistance Application (FAA)**

**Patient Demographics**

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| --- | --- | --- | --- |
| **Patient Name: Last, First, Middle** | **Last 4 digits of Social Security** | **Date of Birth** | **Account #**  **Location of Service** |
| **Guarantor Name: Last, First, Middle** | **Social Security # (If available)** | **Date of Birth** | **Relationship to Patient** |
| **Patient/ Guarantor Address** | **County of Residence** | **Home Phone #** | **Alternate Phone #** |
| **City** | **State** | **Zip Code** | **Homeowner? Yes No** |
| **Have you applied for Medicaid or any other State/County Assistance? (Circle one) Yes No**  **If Yes, Please provide the following:**  **Application Date: Status of Application:**  **Caseworker Name: Caseworker Phone Number:** | | | |

**Household Information**

|  |  |  |
| --- | --- | --- |
| **Marital Status: Married Single Separated Divorced Widowed**  **Family Size:** | | |
|  | | |
| **Family Members** | **Relationship** | **Date of Birth** |
|  |  |  |
|  |  |  |
|  |  |  |

**Employment/Household Income**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Type of Income** | **3 Months Income** | **12 Months Income** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **IF INCOME IS $0, PLEASE EXPLAIN** |  | | |
|  |  |  |  |

**IMPORTANT:** To qualify for assistance, at least one piece of supporting documentation that verifies household income may be required. Supporting documentation can include but is not limited to, current pay-stubs for the household for the last 12 months, signed letter of support, SSI, Social Security, pensions, unemployment, etc.

**To qualify for hospital Financial Assistance Program residency is limited to the following Ohio counties Jefferson, Belmont, Columbiana, Harrison & Tuscarawas and West Virginia counties Brooke, and Hancock.**

Ohio Hospital Care Assurance Program (HCAP): Pursuant to OAC 5160-2-07.17, THS provides, without charge to the individual, basic, medically necessary hospital-level services to individuals who are residents of Ohio, are not Medicaid recipients, and whose income is at or below the federal poverty line. Covered services are inpatient and outpatient services covered under the Ohio Medicaid Program, with the exception of transplantation services and services associated with transplantation. These covered services must be ordered by an Ohio licensed physician and delivered at a hospital where the physician has clinical privileges, and where such services are permissible to be provided by the hospital under its certificate of authority granted under Chapters 3711., 3727., and/or 5119. of the Revised Code of Ohio. Recipients of Disability Financial Assistance qualify for assistance. Ohio residency is established by a person who is living in Ohio voluntarily and who is not receiving public assistance in another state. Requests for financial assistance for Ohio residents are processed for HCAP first, and then are otherwise subject to the provisions of this Policy. In the event that services are not covered by HCAP, to the extent provided by THS, emergency and/or medically necessary care will be considered under the THS financial assistance policy. The following questions pertain to eligibility pursuant to HCAP.

1. Were you an Ohio resident at the time of your hospital service? Yes\_\_\_\_ No\_\_\_\_
2. Were you an active Medicaid recipient at the time of your hospital service? Yes\_\_\_\_ No\_\_\_\_

If yes, Medicaid recipient ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Were you an active recipient of Disability Assistance at the time of your hospital service? Yes \_\_\_\_ No\_\_\_\_

(If you answered Yes to this question, please attach a copy of your DA card effective during your hospital service to this application.)

1. Did you have health insurance (other than Medicaid) at the time of your hospital service? Yes\_\_\_\_ No\_\_\_\_

**PLEASE READ THE FOLLOWING BEFORE SIGNING AND DATING THE APPLICATION**

Please be advised that your signature indicates you have agreed to attach income verification.

* I certify that the information I have provided is true and accurate to the best of my knowledge.
* I will independently or with the assistance of hospital personnel apply for ANY and ALL Assistance which may be available through federal, state, local government and private sources to help pay this healthcare bill.
* I understand that if I do not cooperate with my healthcare provider in providing requested information, my application may be denied for possible financial assistance.
* I understand that the information which I submit is subject to verification by my healthcare provider, including credit reporting agencies and subject to review by Federal and/or State agencies and others as required.
* I understand that additional information may be requested in order to qualify for assistance.

|  |  |
| --- | --- |
| **Signature (Applicant/Guarantor)** | **Date** |

**Return Completed Application and Documents to:**

Trinity Health System

Attn: Financial Counselor

4000 Johnson Road

Steubenville, OH 43952

Phone: (740) 283-7261 Fax: (740) 283-7431**Office Use Only**

|  |  |
| --- | --- |
| HCAP/CHARITY | EXPIRATION DATE: |
| 3 Months Income Total: | 12 Months Income Total: |

**Verification Documents: YES NO**

|  |  |  |
| --- | --- | --- |
| Family Size: |  |  |
| Income: Tax return, pay stubs, or other |  |  |

**Approval (s):**

|  |  |  |  |
| --- | --- | --- | --- |
| Name (Printed) | Name (Signature) | Title | Date |

**Comments:**