Application for Financial Assistance

O Ohio Hospital Care Assurance Program (HCAP)
O Healthcare Financial Assistance Program

Please Print All Information

Patient Name (Last, First, M)		Social Security No.	Date of Birth
Street Address, City, State, Zip Code			Daytime Phone
Date of Service	Hospital Account Number	Are You Insured? O Yes O No	O Single O Married O Widowed O Separated*
Employment Status at time of service: O Employed O Retired O Unemployed			
Were you an Ohio Resident at the time of your hospital service? O Yes O No			
Were you an active Medicaid recipient at the time of your hospital service? O Yes O No If yes, Medicaid billing number: _______________			
Were you an active recipient of disability assistance at the time of your hospital service? O Yes O No			
Spouse's Name (Last, First, M)		Social Security No.	Date of Birth
Employment Status of Spouse at time of service: O Employed O Retired O Unemployed			

Application covers an inpatient stay and/or month of service and the two following months

"Family" includes the patient, patient's spouse ***(regardless of whether they live in the home)** and all patient's children, natural or adoptive, **under the age of 18 who live in the home**. If patient is under the age of 18, the "family" shall include patient, patient's natural or adoptive parent(s) ***(regardless of whether they live in the home)** and the parents' children under the age of 18 who live in the home.

Family Member's Name	Date of Birth	Relationship to Patient	Gross Income received within the three months before month of service (If zero, must complete $0 Income Statement below)	Source of Income or Employer Name
(Patient)		(Self)		
Total Persons in Family:			**Total Family Income:**	

$0 Income Statement: ____________________

Provide brief statement of how basic food/housing needs were met within the three months before date of service

*Income of a spouse or parent who does not live in the home is required unless the absent spouse or parent does not contribute to the household; use INCOME block to document "Does not contribute".

Income verification includes but is not limited to copies of total wages before taxes, pension, SSI/SSD/Unemployment benefits, alimony, child support (if child is patient), veterans· benefits, distributions from a retirement account (IRA), 401(k), and 401(b).

If you receive Social Security or Disability Benefits, a letter of income verification or your most recent 1099 form may be submitted. A letter of verification can be obtained by calling the Social Security Administration at 1.800.772.1213.

I, the undersigned, have provided the above information to be considered for financial assistance through Summa Health System and;

To the best of my knowledge. I state this to be true and accurate information. and;

I understand that these are Federal funds and accept the responsibility of their use on my behalf. and;

I understand that Summa Health System reserves the right to modify or cancel this program in accordance with the rules of the Ohio Department of Jobs and Family Services (ODJFS).

X ____ ____________________

(PATIENT OR A LEGAL REPRESENTATIVE OF A PATIENT MUST SIGN FOR APPLICATION TO BE VALID) (DATE)

X ____ ____________________

(HOSPITAL REPRESENTATIVE SIGNATURE/DEPT. OR AGENCY) (DATE)

Important Notice To Our Patients

Financial assistance programs apply only to hospital charges. Programs do not include any physician or professional billing fees.

Policy Statement

Summa Health System is committed to providing financial assistance responsive to the needs of the community, regardless of race, age, gender, color, ethnic background, national origin, citizenship, primary language, religion, disability, handicap, education, employment or student status, disposition, relationship, insurance coverage, community standing, or any other discriminatory differentiating factor. Healthcare Financial Assistance ("HFA") is a program that is fully funded by Summa Health System. It covers patients without health insurance and those with only partial insurance coverage (i.e. the uninsured and underinsured) who meet the income and other eligibility criteria.

Health Insurance Marketplace (Exchange) Participation

- If a patient has elected not to enter the marketplace/exchange, financial assistance may not be extended until they do so. Exceptions to this policy include patients discharged to a SNF, patients who are deceased with no estate, and patients who have documented homelessness.
- Healthcare financial assistance may be offered once the patient meets the requirement for insurance.

ANNUAL INCOME					
Family Size	**HCAP** 100% FPL 100% Discount	**Charity** 101-250% FPL 100% Discount		**Charity** 251-400% FPL AGB = 85% Discount	
1	$13,590	$13,591	$33,975	$33,976	$54,360
2	$18,310	$18,311	$45,775	$45,776	$73,240
3	$23,030	$23,031	$57,575	$57,576	$92,120
4	$27,750	$27,751	$69,375	$69,376	$111,000
5	$32,470	$32,471	$81,175	$81,176	$129,880
6	$37,190	$37,191	$92,975	$92,976	$148,760
7	$41,910	$41,911	$104,775	$104,776	$167,640
8	$46,630	$46,631	$116,575	$116,576	$186,520

Add $4,720 for each additional person
Effective for dates of service beginning on 01/12/2022

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Complete policy available at **summahealth.org/patientvisitor.**

Summa Health System – Patient Account Services
P.O. Box 2090
Akron, OH 44398-6153

Summa Health System – Akron Campus • Summa Health System – Barberton Campus • Summa Health System – St. Thomas Campus