



Summa Financial Assistance Application Checklist:

Please use this checklist to make sure you have the required documentation included with your financial assistance application.

Photo ID and income verification required for all family members as defined under "Family" on the application.

Identification:

- ☐ Photo ID/Driver's License/Passport
- ☐ Proof of Ohio Residency (Utility bill, cable, telephone, letter from landlord)

Proof of other medical coverage: provide documentation with the application.

- ☐ Health Insurance (VA Benefits, Medicare, Medicaid, Commercial)
- ☐ Workers Compensation
- ☐ Motor Vehicle Accident Coverage

Income Verification: **Must show recipient/employees name**

Unemployed, \$0 income.

- ☐ Statement of how basic food/housing needs were met for 3 months prior to date of service.

Unemployed, collecting unemployment.

- ☐ Unemployment payment history for 3 months prior to date of service

Self Employed/1099 (**Provide one of the below**)

- ☐ Most recent signed tax return including schedule C form and 1099 (in case of filing extensions, prior year's tax return accepted until June of current year)
- ☐ Statement from employer if paid by company or single individual and 6 months of bank statements prior to date of service.

Traditional Employment/W2 (**Provide one of the below**)

- ☐ Paid Weekly? 12 pay stubs prior to date of service
- ☐ Paid Bimonthly? 6 pay stubs prior to date of service
- ☐ Paid in Cash/Personal Check? letter from employer and 3 months of bank statements prior to date of service
- ☐ Most Recent signed Tax Return, W2 and 3 months of bank statements prior to date of service (in case of filing extensions, prior year's tax return accepted until June of current year)

Retired

- ☐ Social Security Retirement or Supplemental Income Benefits
A letter of verification can be obtained by calling the Social Security Administration at 1-800-772-1213
- ☐ Pension or Retirement Account distributions (IRA, 401k, 403b)

Verification of other income: **Must show recipients name**

- ☐ Alimony
- ☐ Child Support *Only if the applicant/patient is the child*
- ☐ Other (rental income, etc.)
- ☐ Veteran Disability Compensation
- ☐ Social Security Disability or Survivor Benefits

A letter of verification can be obtained by calling the Social Security Administration at 1-800-772-1213



Application for Financial Assistance

- ☐ Ohio Hospital Care Assurance Program (HCAP)
- ☐ 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? <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Separated*
Employment Status at time of service: <input type="radio"/> Employed <input type="radio"/> Retired <input type="radio"/> Unemployed			
Were you an Ohio Resident at the time of your hospital service? <input type="radio"/> Yes <input type="radio"/> No			
Were you an active Medicaid recipient at the time of your hospital service? <input type="radio"/> Yes <input type="radio"/> No If yes, Medicaid billing number: _____			
Were you an active recipient of disability assistance at the time of your hospital service? <input type="radio"/> Yes <input type="radio"/> No			
Spouse's Name (Last, First, M)		Social Security No.	Date of Birth
Employment Status of Spouse at time of service: <input type="radio"/> Employed <input type="radio"/> Retired <input type="radio"/> Unemployed			

"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 403(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)

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% Federal Income Guidelines 100% Discount	Charity 101-250% Federal Income Guidelines 100% Discount		Charity 251-400% Federal Income Guidelines Amount Generally Billed based on claims = 86% Discount	
1	\$15,650	\$15,651	\$39,125	\$39,126	\$62,600
2	\$21,150	\$21,151	\$52,875	\$52,876	\$84,600
3	\$26,650	\$26,651	\$66,625	\$66,626	\$106,600
4	\$32,150	\$32,151	\$80,375	\$80,376	\$128,600
5	\$37,650	\$37,651	\$94,125	\$94,126	\$150,600
6	\$43,150	\$43,151	\$107,875	\$107,876	\$172,600
7	\$48,650	\$48,651	\$121,625	\$121,626	\$194,600
8	\$54,150	\$54,151	\$135,375	\$135,376	\$216,600

For Families/Households with more than 8 persons, add \$5,500 for each additional person

Effective for dates of service beginning on 01/01/2025

"Family" includes the patient, their 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**, Stepchildren, grandchildren unless legally adopted are not counted in the family for purposes of these programs.

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