TRINITY HOSPITAL TWIN CITY

Trinity Hospital Twin City Financial Assistance Application (FAA)

Patient Demographics

Patient Name: Last, First, Middle	**Social Security # (If available)**	**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**

Dependent Names	**Relationship**	**Date of Birth**

Employment/Household Income and Expenses

Patient/Guarantor Employer Name	**Gross Monthly Income: $**	**Provide verification**
If income is $0, please explain.		**Provide documentation**
Spouse's Employer Name	**Gross Monthly Income: $**	**Provide verification**
If income is $0, please explain.		**Provide documentation**
Other Income Source:	**Gross Monthly Income: $**	**Provide verification**
EXPENSES ARE NOT REQURIED FOR NHSC APPLICATIONS		
Household Monthly Expenses	**Total Monthly Expenses: $**	

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, most recent year's tax return, a current W-2, 3 months of current pay-stubs, signed letter of support, etc.

Ohio Hospital Care Assurance Program (HCAP): Pursuant to OAC 5160-2-07.17, THTC 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 limit. 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 provider and delivered at a hospital where that provider 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 Ohio Revised Code. 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 THTC, emergency and/or medically necessary care will be considered under the THTC financial assistance policy. The following questions pertain to eligibility pursuant to HCAP:

1. Were you an Ohio resident at the time of your hospital services? Yes _____ No _____

2. Were you an active Medicaid recipient at the time of your hospital service? Yes _____ No _____
   If yes, please provide your Medicaid ID number _____

3. 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 to this application a copy of your DA card effective during your hospital service)
4. 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 Hospital Twin City
Attn: Financial Counselor
819 N First Street
Dennison, OH 44621

Phone: (844)-428-7500
Fax: (740) 922-7414

TRINITY HOSPITAL TWIN CITY

Office Use Only

Reason for visit:	FPL%
Total Charges: $	Total Adjustment: $

Verification Documents:

	YES	NO
Identification/Address: Driver's license, picture ID, or other		
Family Size/Income: Tax return, pay stubs, or other		

Approval (s):

Name (Printed)	Name (Signature)	Title	Date
Name (Printed)	Name (Signature)	Title	Date
Name (Printed)	Name (Signature)	Title	Date
Name (Printed)	Name (Signature)	Title	Date

Comments: _____