www.heartofohiofamilyhealth.org

Capital Park Family Health Center
2365 Innis Road
Columbus, Ohio 43224
614-416-4325

Whitehall Family Health Center
882 South Hamilton Road
Columbus, Ohio 43213
614-235-5555

FINANCIAL ASSISTANCE PROGRAM
Information and Application

Welcome!

Thank you for choosing Heart of Ohio Family Health Centers (HOFHC) to be the provider of your medical care. As a Federally Qualified Health Center, a Financial Assistance Program (FAP) is available for patients who do not have health insurance coverage or do not qualify for other assistance. The FAP reduces the patient's cost for medical care and services based on household size and total household income.

Please follow the application instructions to be considered for the HOFHC Financial Assistance Program.

Patients with disability assistance through the Department of Human Services automatically quality for assistance at HOFHC. Please provide a copy of the patient's Disability Acceptance Card.

We look forward to working with you for the best of health care.

Sincerely,
Heart of Ohio Family Health Centers Providers and Staff

In the community for the community

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FINANCIAL ASSISTANCE PROGRAM GUIDELINES

REQUIRED DOCUMENTS – PROOF OF INCOME

1. Proof of employment income
    a. Paystubs for the past 60 days
    b. Letter from employer on Company Letterhead stating the rate of pay and total hours
    c. Most recent year's tax return including 1040 and all schedules or IRS form 4506-T
2. Proof of other income (award letters)
    a. OWF cash assistance
    b. Child Support/Alimony
    c. Unemployment
    d. Worker's Compensation
    e. Social Security (Any)
    f. Disability (Any)
    g. Rental property income
    h. Other: retirement, pension, annuities, investments, or savings
3. No income members
    a. All members of the household over 18 years of age with no income must provide a notarized Zero Income Affidavit
    b. If there is NO INCOME in the Household, the Head of Household must also provide a notarized statement of support detailing how the household is paying for living, food, and shelter expenses.

REQUIRED DOCUMENTS – PROOF OF IDENTITY, RESIDENCY, AND DEPENDENCY

4. Birth Certificates or court documents for dependent child(ren) under the age of 18
5. Government/School issued photo ID for members over the age of 18
6. Proof of residency for all members over the age of 18
    a. Utility or Telephone Bill
    b. Bank or credit card statement
    c. Government/School issued photo ID issued to the address on the application
    d. Government/School issued mail (personal and bulk mail are NOT acceptable)

HOUSEHOLD AND INCOME DEFINED

"Household Size" is defined as immediate family members who reside at the same address. You MUST include your spouse or domestic partner as part of your household and provide their income. Generally, children over the age of 18 and other adults (not spouse or domestic partner) cannot be included as part of your household.

"Income" is defined as ALL earned and unearned income and must be reported for ALL household members. Examples of income includes but is not limited to: work earnings, self employment earnings, alimony and child support received, all types of Social Security awards, OWF cash assistance, Worker's Compensation awards, retirement/pension, annuities, and rental property income.

HOUSEHOLD SIZE	MAXIMUM ANNUAL INCOME TO QUALIFY FOR SLIDING FEE
1	$21,780
2	$29,420
3	$37,060
4	$44,700
5	$52,340
Add $7,640 for each additional member	

Please complete the enclosed Financial Assistance Application and provide ALL supporting documents for processing. We cannot determine eligibility without a completed application and all required documents.

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FINANCIAL ASSISTANCE PROGRAM APPLICATION

PERSONAL INFORMATION

Last Name: _____ **First Name:** _____ **M.I.** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell/Alt Phone:** _____

Date of Birth: _____ **Social Security #:** _____ **Number of Household Members?** _____

HOUSEHOLD MEMBER INFORMATION

Please provide the following information for each member of your household. (List yourself first)

Last Name/First Name	Social Security #	Date of Birth	Relationship	HOFHC Patient?
1.			SELF	☐ Yes ☐ No
2.				☐ Yes ☐ No
3.				☐ Yes ☐ No
4.				☐ Yes ☐ No
5.				☐ Yes ☐ No

INCOME INFORMATION

Please provide the "Gross" incomes for each member of your household. List yourself first. (Gross =Before Taxes)

Income Source	SELF	Member 2	Member 3	Member 4	Member 5	STAFF USE ONLY
Employment (or Self Employment)	$	$	$	$	$	Application Received
How often received?						Date_____
Disability (worker's comp, SSDI, other)	$	$	$	$	$	Application Reviewed
How often received?						Date _____
Unemployment, OWF cash assistance	$	$	$	$	$	☐ Proof of income received
How often received?						☐ Proof of dependency received
Child Support/Alimony (Received)	$	$	$	$	$	☐ Incomplete application; patient advised to bring additional documents
How often received?						
Social Security/Retirement/Pension	$	$	$	$	$	_____
How often received?						_____
Other: Investments, rental income settlements or trusts	$	$	$	$	$	_____
How often received?						_____
						_____
Check if Member is Student/Child	☐	☐	☐	☐	☐	Due Date _____
Check if NO Income (unemployed)	☐	☐	☐	☐	☐	Staff Initials and date
TOTAL INCOME	$	$	$	$	$	_____

PATIENT ACKNOWLEDGEMENT

I certify that all information provided is true and accurate to the best of my knowledge. I understand that providing false information or false documentation may result in removal from the Financial Assistance Program, possible termination from the practice, and I will forfeit any discounted cost of services.

Patient Signature _____ *Date* _____

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ZERO INCOME AFFIDAVIT

PERSONAL INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell/Alt Phone: _____

Date of Birth: _____ Social Security #: _____ Number of Household Members? _____

NO INCOME STATEMENT

I, _____ state that I have not received any source of income since _____.
Print Your Name Date

I hope and expect to receive income on or about _____ from _____.
Date List Source of Expected Income

COST OF LIVING STATEMENT

During the above period, how did you and/or your household meet their needs for:

FOOD: _____

_____

_____

SHELTER: _____

_____

_____

LIVING EXPENSES: _____

_____

_____

PATIENT ACKNOWLEDGEMENT (NOTARY REQUIRED)

I understand that I can be denied Financial Assistance for making false statements, and I do reaffirm that all claims here are complete and truthful to the best of my knowledge.

Patient Signature: _____ *Date:* _____

DO NOT SIGN until in the presence of a Notary

Sworn to and subscribed in my presence by _____

on this _____ ***day of*** _____ ***year*** _____. ***My commission expires*** _____ ***year*** _____.

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PATIENT CONSENT AND AUTHORIZATION

This consent is valid for one (1) year or sooner **if requested in writing**.

RECORD OF RECEIPT AND MESSAGE PERMISSION

1. I have received a copy of the HOFHC Patient Handbook including my rights and responsibilities ☐ YES ☐ NO
2. HOFHC is allowed to leave a message on my voicemail/answering machine ☐ YES ☐ NO
4. HOFHC is allowed to contact me via E-mail ☐ YES ☐ NO
5. I give permission for HOFHC to discuss my health information with the following person:

Name _____ Relationship to Patient _____ Phone Number _____

CONSENT TO MEDICAL CARE AND TREATMENT

While at Heart of Ohio Family Health Centers (HOFHC), I consent to all medical care, examinations, and tests determined to be necessary for me. Though I expect the care given to meet customary standards, I understand that there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me, I will not hold HOFHC or any individual responsible for any of the consequences. I understand that I am being established by HOFHC as a recurring patient to be provided a series of ongoing services based on my provider's orders.

RELEASE OF INFORMATION

I understand HOFHC may use my health information for a range of purposes including: insurance/payment eligibility verification, billing and collecting moneys due from me, private and public payers or their agents including insurance companies, managed care entities, my employer and state and federal government programs obtaining pre-admissions or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance or qualifications of physicians and health care ensuring compliance with legal, regulatory and accreditation requirements, performance of autopsies, and public health activities. I authorize HOFHC to receive or release my health information, whether written, verbal, electronic–including secured internet websites–or by facsimile to such employees, agents or third parties as are necessary for these purposes and to companies who provide billing services for physicians or other providers involved in my medical care. I understand that complete, accurate health information must be readily available for my medical care. Therefore, I authorize HOFHC to release health information to my family physician, referring physician or agency(ies) in order to facilitate continuity of care. I understand that the information shared with health care professionals as a result of this authorization will remain confidential. The preceding authorizations for release of medical information include authorization for the release of information regarding drug and/or alcohol abuse, HIV (Human Immunodeficiency Virus) testing or HIV infection related conditions.

RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of HOFHC's Notice of Privacy Practices and have had a chance to object to the use or disclosure of my information for directory, disaster relief, or to provide information to family or persons involved in my care.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of all insurance benefits to be made directly to HOFHC for services related to this encounter. I acknowledge that if the ID card present at the time of service is not valid, I will be responsible for payment.

STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS AND/OR COMMERCIAL INSURANCE BENEFITS TO PROVIDER

I certify that the information given by me in applying for Medicare payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release this information to my health insurers. I request that payment of authorized benefits be made on my behalf. I authorize HOFHC to bill Medicare Lifetime Reserve Days, as necessary. I assign the benefits payable for physician services (including emergency, radiology, pathology, dialysis, EKG, EEG, physical therapy, anesthesia and other hospital-based physician services) to the hospital-based physician or organization furnishing the services (if assignment is accepted) and authorize the physician or organization furnishing the services to bill Medicare, Medicaid, and/or commercial insurance a carriers for payments. I also assign the benefits payable for private and attending physician services to my private/attending physicians or his/her private practice organization, providing, however, that should my private/attending physician NOT ACCEPT THIS ASSIGNMENT AS PAYMENT IN FULL for his/her services, I understand I am responsible for full charges.

FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred, which are not paid by insurance benefits. I agree to pay HOFHC for charges incurred including incidentals. I understand that charges due by the patient, but not paid within 30 days of billing may be subject to interest. I understand that services rendered to me may not be eligible for benefits under Medicare, Medicaid, or other providers who do not participate with my insurance plan. Non-covered services may also include those my physician determines medical necessary, but are later determined unnecessary by my insurance plan.

PERSONAL VALUABLES

HOFHC does not accept responsibility for any lost, stolen, or damaged personal items. I accept responsibility for items I choose to keep with me at HOFHC.

MEDICARE RIGHTS NOTIFICATION LETTER

If I have Medicare, I acknowledge receipt of the Medicare Rights Notification letter.

SOCIAL SERCURITY ADMINISTRATION RELEASE

I authorize the Social Security Administration to release to HOFHC information pertaining to my Medicare entitlement.

Printed Patient Name: _____ *Date:* _____

Patient/Guardian Signature: _____ *Date:* _____

Staff Signature: _____ *Date:* _____

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PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Last Name: _____ **First Name:** _____ **M.I.** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell/Alt Phone:** _____

Gender: ☐ Male ☐ Female **Date of Birth:** _____ **Social Security #:** _____

Employer: _____ ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled

Are you a Student? ☐ Full time ☐ Part time ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Email: _____ **Who referred you to our office?** _____

Emergency Contact Name: _____ **Phone:** _____ **Relationship to Patient:** _____

RESPONSIBLE PARTY/GUARANTOR IF DIFFERENT FROM THE PATIENT

Responsible Party Last Name: _____ **First Name:** _____ **M.I.** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell/Alt Phone:** _____

Gender: ☐ Male ☐ Female **Date of Birth:** _____ **Social Security #:** _____

Employer: _____ **Email:** _____

MEDICAL INSURANCE INFORMATION (Must Present Insurance Card)

Primary Insurance Company: _____ **ID Number:** _____

Name of Insured: _____ **Gender** ☐ Male ☐ Female

Insured Date of Birth: _____ **Relationship to Patient:** ☐ Self ☐ Other _____

Secondary Insurance Company: _____ **ID Number:** _____

Name of Insured: _____ **Gender** ☐ Male ☐ Female

Insured Date of Birth: _____ **Relationship to Patient:** ☐ Self ☐ Other _____

ADDITIONAL INFORMATION

Country of Origin: _____ **Language:** _____ **Do you need an Interpreter?** ☐ Yes ☐ No

Race: ☐ Black/ African-American ☐ White ☐ American Indian/Native Alaskan ☐ Asian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Multiple Races ☐ Decline to respond

Ethnicity: **Hispanic/Latino** ☐ Yes ☐ No

Are you a Migrant Worker? ☐ Yes ☐ No **Seasonal Worker?** ☐ Yes ☐ No **Homeless?** ☐ Yes ☐ No **Veteran?** ☐ Yes ☐ No

Are you a legal resident/citizen of the United States? ☐ Yes ☐ No
(used only to determine eligibility of certain health care programs and is not reported to any government or law enforcement agency)

I hereby authorize my insurance carrier to pay benefits directly to Heart of Ohio Family Health Centers (HOFHC). I authorize HOFHC to release any information acquired in the course of my treatment for my medical claims. I understand that I am responsible for all payments and co-insurance amounts, non-covered supplies and services and yearly deductibles. I understand that payment is expected at the time services are rendered. I certify that the above information is correct to the best of my knowledge.

Patient Signature: _____ *Date:* _____

Parent/Guardian Signature: _____ *Date:* _____