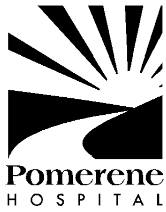


981 Wooster Road
Millersburg, OH 44654
(330) 674-1015, extension 1163

POMERENE HOSPITAL
CHARITY CARE PROGRAM

REQUIREMENT LIST

Name of Patient: _________________

Date of Service: __________________

Account Number: ________________

Dear Applicant,

Enclosed please find an application for the Pomerene Hospital Charity Care program. Please complete all items as they pertained to your financial situation on the **date of service.** In addition to the application, you must include all of the following documentation in order for your application to be processed.

EMPLOYED APPLICANT

- Proof of income (and spouse if applicable): three months pay stubs prior to the date of service
- Income tax return, ONLY if you cannot produce the three most recent pay stubs
- Letter from employer verifying gross income

SELF EMPLOYED APPLICANT

- Income tax return
- Statement from a certified public accountant verifying gross income

UNEMPLOYED APPLICANT

- unemployment stubs or the unemployment letter showing weekly benefits
- "Statement of support" form, if no income (included in packet)
- Workmen's compensation stubs
- Disability benefits and/or SSI benefits, if the patient is the sole intended family member designated to receive the support

RETIRED APPLICANT

- Social security benefits yearly statement or letter from social security office indicating monthly payment

INCLUDE FOR PATIENTS OVER 18 ONLY

- Pension or veteran's benefits

OTHER TYPES OF INCOME

- Child support (if the patient is the child), and alimony may provide divorce papers or court order statement indicating amount received

ASSETS

- Copies of bank statements showing balance as of date of service. This includes checking account, savings account, CD's, IRA, retirement funds, stocks and bonds.

AMISH CHURCH FUND/AMISH AID

- Authorization for release of billing information needs signed
    - church district, church number, name of deacon

PROOF OF RESIDENCY (May use any one of the following documents) PO BOX **not** acceptable-must see physical address.

- Copy of driver's license
- Utility bill with your name and address
- Lease/deed

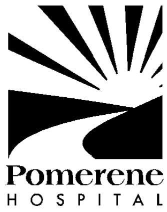
PROOF OF MEDICAID DENIAL

- If we determine that you may be eligible for Medicaid, or other assistance, you will be expected to apply for Medicaid before we can process the PHCC application. If you were denied Medicaid coverage, the denial letter is required.

Please be advised that any incomplete documentation will delay the application process and require us to deny your application until the appropriate documentation is received. Please only send us copies of documents NOT originals, as we will not return any that we receive.

Financial assistance and charity care are secondary to ALL other financial resources available to patient. This may include:

- Health Savings Accounts
- Health Flexible Spending Accounts
- Worker's compensation
- Medicare
- Medicaid
- Third party liability situations (auto accidents/personal injury)
- Victim's Assistance
- Other state, federal, and military programs
- Church Fund
- Amish Aid



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POMERENE HOSPITAL
CHARITY CARE PROGRAM

Hospital Care Assurance Program (HCAP). The government of the State of Ohio, in collaboration with the United States federal government, has sponsored, funded, and implemented an Expanded Hospital Care Assurance Program, which was effective May 22, 1992. According to this program, "hospitals that receive payments under the provision of Chapter 51212 of the Ohio Revised Code shall provide, **without charge** to the individual patient, basic, medically necessary, hospital-level services to the individuals who are residents of this State, are not recipients of the Medicaid program, and whose income is at or below the federal poverty line." Pomerene Hospital, which receives funds under this federal/state government program, is required by law to participate in the *Care Assurance Program*.

The 2014 federal poverty income guidelines for HCAP:	
Family Size	
1	$11,670
2	$15,730
3	$19,790
4	$23,850
5	$27,910
6	$31,970
7	$36,030
8	$40,090

Pomerene Hospital Charity Care Program (PHCC). Pomerene Hospital is concerned with the health of our community and will provide a reasonable amount of care either at no charge or at a reduced charge to individuals who are residents of Holmes County and eligible under the Pomerene Hospital *Charity Care Program*.

Size of Family	**GREATER THAN**	**UP TO**	**GREATER THAN**	**UP TO**	**GREATER THAN**	**UP TO**
1	$11,670	$14,588	$14,589	$17,505	$17,506	$20,423
2	$15,730	$19,663	$19,664	$23,595	$23,596	$27,528
3	$19,790	$24,738	$24,739	$29,685	$29,686	$34,633
4	$23,850	$29,813	$29,814	$35,775	$35,776	$41,738
5	$27,910	$34,888	$34,889	$41,865	$41,866	$48,843
6	$31,970	$39,963	$39,964	$47,955	$47,956	$55,948
7	$36,030	$45,038	$45,039	$54,045	$54,046	$63,053
8	$40,090	$50,113	$50,114	$60,135	$60,136	$70,158
Patient Share of Usual Charge	**25%**			**50%**		**75%**

Add $4,060 for each additional person if the family unit has more than 8 members.

INCLUDE FOR PATIENTS OVER 18 ONLY

<u>Frequently asked questions</u>

1. **What is included with "family size"?**
   a. Family size includes the patient, patient's spouse whether they reside in the home or not and ALL of the patient's children, natural or adopted under the age of 18. Grandparents, step-parents and legal guardians are not considered part of a minor patient's "family". They must be related by birth or formal adoption in order to be considered. Both parents should be counted if the child is the patient, even if only one of them has been granted responsibility. Siblings who reside in the home can only be counted in the family size.

2. **What is considered "income"?**
   a. Income would be considered as anything made from employment, unemployment, alimony, child support, and funds in a retirement account, distributions from a retirement account, interest and dividends on a non-retirement savings or brokerage account, and social security income. Child support, SSI, and Social Security Disability are only used as an income source if the patient applying is the sole intended family member designated to receive that support. Grants, scholarships, and housing allowances that are paid directly to a student/patient are considered income as well. Patients who are still married need to include the spouse's income even if the spouse no longer lives in the home. If you are unable to obtain that figure, a descriptive reason needs to be documented with your application.

3. **Who is eligible for PHCC?**
   a. Residents of Holmes county who:
      i. Meet the income criteria
      ii. Have completed an HCAP application
      iii. Have no health coverage or have coverage that only pays part of the bill.
      iv. Are ineligible for any private or government sponsored coverage (such as Medicaid)

4. **What services are covered under PHCC?**
   a. Only medically necessary and emergency health care services are covered.

If I receive a discount off my bill from PHCC, how do I set up payments for my balance?

- Once your application has been processed, you must **<u>immediately</u>** set up payments for the balance, no longer than 10 days after notification. You can do so by contacting the Financial Counselor at 330-674-1584, ext. 1163. **<u>Please note-failure to pay the balance on your account will result in your PHCC discount being reversed, and the full original balance going to collections. Once this is done, you are not eligible for PHCC again for this account.</u>**

PHCC INFORMATION

- A PHCC application will not be processed until an HCAP application has been completed.
- HCAP is applicable 3 years from the date of your first statement
- PHCC is applicable 1 year from the date of your first statement
- A bill totaling less than $100 will not be eligible for PHCC.
- If the patient has Amish Church Fund or Amish Aid, an application will not be processed until an authorization for release has been signed, so that Pomerene Hospital may discuss your account with your church Deacon.
- Only the patient (if not a minor), patient's spouse, legal guardian, or financial POA can sign the application.
- If the applicant/patient is deceased, the application must be completed by someone who is legally able to speak for the patient, so an executor of their estate would be the first choice. If there is no executor of the estate-the patient's next of kin could sign and attest to the validity of the information on the application.
- An application filed for an outpatient service will be active for 3 months from the original visit date. An application for any inpatient service will require a new application be filled out, unless a following inpatient admission pertains to the same admitting diagnosis.
- Our Financial Counselor is here to assist you with your application. Please call Mon-Fri 8a.m. - 4:30 p.m. 330-674-1584, ext. 1163 for an appointment.

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POMERENE HOSPITAL CHARITY CARE PROGRAM

Patient Information

Date:________________

Name:_________________________________ Patient's Date of Birth:__________________

I attest that I am: Single Married Legally Divorced Widowed

Account Number:_____________ Date of Service:__________________________

Physical Address: ________________________________County_____________________

Mailing Address: ____

Primary Phone Number :___________________ Spouse Name / DOB: ________________

Family Information

Please provide the following information for all people in your immediate family who live in your home. For purposes of HCAP, family is defined as the patient, the patient's spouse, and the patient's children (natural or adopted and under 18) who reside in the patient's home. If the patient is a minor, the family should include the patient, the patient's natural or adoptive parents (whether they reside in the home or not), and the patient's siblings (natural or adopted and under 18) who live in the home. Grandparents, step-parents and legal guardians are not considered part of a minor patient's "family" per HCAP guidelines.

Name	Date of Birth	Relationship to the Patient

INCLUDE FOR PATIENTS OVER 18 ONLY

Family Income

List income for yourself, your spouse, and all other family members

Income Source	Name of the Recipient of Income	Relationship to the patient (self, spouse, family member)	Monthly Gross Amount	Proof of Income needed to accompany application
Wages/Self employment				3 months paystubs prior to the date of service, or most recent W2/Tax Return
Social Security Disability				Social Security Benefit Letter/Bank Statement
Social Security Retirement				Social Security Benefit Letter/Bank Statement
Pension, Dividends, Interest, Other Income				Benefit letter/Statement
Unemployment				Unemployment Letter

Do you have assets over $5,000 in a savings or checking account? If yes, how much? ________

Do you have a Health Savings Acct? _______ If yes, have you exhausted those funds? ______

If you reported $0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs: ____

____

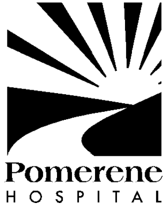
______I attest that I have ______dependent children who reside with me. Only include children who are natural or adopted under the age of 18.

AUTHORIZATION AND AGREEMENT

I hereby submit the above information for the purpose of allowing Pomerene Hospital to evaluate my financial status and determine my eligibility for various financial assistance programs, and do hereby authorize Pomerene Hospital to verify this information as necessary, which may include a credit bureau report, employment, and/or income verification, and appropriate supporting documents.
I attest that the above information and all income documentation provided are complete and accurate as shown. I realize that should, at any time, any of this information prove to be false, all Financial Assistance grants awarded will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances. By applying for Financial Assistance, I also agree to accept payment responsibility for any amount due from me as a result of any partial discount, which may be awarded.

Patient/Guarantor Signature:_______________________________ Date:___981

INCLUDE FOR PATIENTS OVER 18 ONLY



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POMERENE HOSPITAL
CHARITY CARE PROGRAM

PATIENT ATTESTATION

INCOME VERIFICATION

This is to state that I ____have never worked.
____have not worked since _____________.
____am retired.
____am on Disability and/or SSI

ASSETS VERIFICATION

This is to state that I have (a) _____checking account ______savings account

_____other financial assets ______no financial assets

INSURANCE VERIFICATION

_____This is to state that I do not have any medical insurance. I am not being medically treated for any injury related to a motor vehicle, job, or violent crime.

FEDERAL INCOME TAX RETURN

_____This is to state that I did not file a federal income tax return for _______(year).

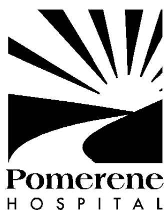
OHIO/HOLMES COUNTY RESIDENCY

_____ I currently live in Holmes County, Ohio.

PRINT NAME:____**DATE**:_________________

SIGNATURE:____

INCLUDE FOR PATIENTS OVER 18 ONLY



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POMERENE HOSPITAL
CHARITY CARE PROGRAM

SPOUSE ATTESTATION

INCOME VERIFICATION

This is to state that I ____have never worked.
____have not worked since _____________.
____am retired.
____am on Disability and/or SSI

ASSETS VERIFICATION

This is to state that I have (a) _____checking account ______savings account

_____other financial assets ______no financial assets

INSURANCE VERIFICATION

_____This is to state that I do not have any medical insurance. I am not being medically treated for any injury related to a motor vehicle, job, or violent crime.

FEDERAL INCOME TAX RETURN

_____This is to state that I did not file a federal income tax return for _______(year).

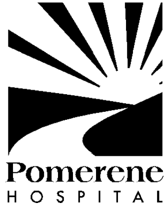
OHIO/HOLMES COUNTY RESIDENCY

_____ I currently live in Holmes County, Ohio.

PRINT NAME:____**DATE**:_________________

SIGNATURE:____

INCLUDE FOR MARRIED APPLICANT



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POMERENE HOSPITAL
CHARITY CARE PROGRAM

STATEMENT OF SUPPORT

I, the undersigned ____________________________ am the _____________________
(Person supporting patient) (Relationship to patient)

of _________________________________. I recognize him/her and attest that he/she
(Patient)

resides/resided with me at the following address ___________________________________

____ from ______________ to _____________.
(Date) (Date)

During that time I provided food, shelter, and basic necessities.

I am in no way responsible for his/her medical bills.

Signature:__________________________________ Date:___________________________
(Person supporting patient)

I may be reached at __________________________________ if you have any questions.
(Phone number)

INCLUDE FOR UNEMPLOYED APPLICANT