

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



Capital Park Family Health Center
2150 Agler Road
Columbus, Ohio 43224
(614) 416-4325

FINANCIAL ASSISTANCE PROGRAM OVERVIEW

Heart of Ohio Family Health Centers is a Federally Qualified Health Center that provides a financial assistance program for uninsured patients who reside in Ohio. The program is a cost share between you and our practice, and is based on household size, and income. We are not a free clinic and you will be responsible for your payment at the time services are rendered. Your participation in the program is dependent upon your ongoing compliance with the prompt payment policy and all other HOFHC office policies.

If you have questions regarding the application and the requirements please call the office and ask to speak to a financial counselor.

Household Members

- All dependant children
- Your spouse or domestic partner
- Other adults or children for whom you are financially responsible (if you provide 50% of their total living expenses)
- Other adults who are responsible for your medical expenses

Income

- Any earned and unearned income for every household member.
 - All money earned from employment as well as trust funds, interest, other settlements, annuities, rental or farm income.
 - Cash assistance awards (welfare)
 - Unemployment
 - Workers' Comp
 - Social Security, (SSI or SSDI)
 - Child support and alimony

Eligibility

- Eligibility lasts for one year from the date of approval.
- Redeterminations during 11th month of current eligibility period.
 - Requires re-verification of income
 - Level of assistance is subject to change
- All Heart of Ohio Family Health Center rules should be adhered to. Failure to comply with the prompt pay policy and all financial assistance requirements may result in suspension of your financial assistance.
- To ensure all patients are held to the same application requirements and are acting in good faith, Heart of Ohio Family Health Centers will take all appropriate steps to verify that the information you provide is true and accurate. **If any document or other information is falsified in order to receive financial assistance you will be automatically removed from the program and further action may be taken.**

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FINANCIAL ASSISTANCE PROGRAM FREQUENTLY ASKED QUESTIONS

Q: Is this a free clinic?

A: No. We are not a free clinic. We offer a discounted fee to those who qualify.

Q: How do I apply for financial assistance?

A: Complete a financial assistance application and bring all requested documents. The reception staff will process your application and inform you of your payment obligation.

Q: I have HCAP approval. Why do I need to fill out another application?

A: HCAP is for hospitals only. Our program is separate from HCAP and therefore you will need to complete our application process.

Q: I have no income. What documents will I need to bring in?

A: We have a list of acceptable documents included in the application packet. If you declare ZERO income you will need to provide an IRS form 4506-T (You can get this at IRS building: 200 North High Street, Columbus, Ohio 43215) and provide a notarized income affidavit.

Q: How is my payment determined?

A: Our sliding fee scale is based on the Federal Poverty Guidelines. Your payment is determined by your household size and total household income.

Q: Why can't you tell me how much I will owe over the phone?

A: We can only quote our usual and customary fees over the phone. We cannot determine your eligibility or payment amount without reviewing your application and supporting documents.

Q: Do I have to pay my co-pay at every visit?

A: Yes. Our office policy is that you pay your co-pay at the time of service. We may make exceptions for extenuating circumstances but only after a payment plan has been arranged.

Q: My doctor wants me to come frequently and I cannot afford to make my payment so many times each month. What can I do?

A: We want you to be compliant with your doctor's recommendations. If you have more than 3 visits per month we can defer payment of the additional visits and establish a payment plan.

Q: All I brought is today's payment but my doctor wants me to have lab work done today too.

A: Always follow your doctor's recommendations. We can bill you for the additional lab fees. If you have not paid your lab fees before your next appointment, be prepared to pay the balance in addition to that day's payment.

Q: I have other questions that have not been answered. Who can I talk to?

A: Please call our office and ask to speak to a financial counselor.

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FINANCIAL ASSISTANCE PROGRAM APPLICATION

COMPLETE THE ATTACHED APPLICATION AND PROVIDE COPIES OF THE FOLLOWING:

- Proof of income for **ALL** household members.
 - 3 recent pay stubs (within last two months) **OR** one or both of the following
 - Letter from the employer on company letterhead stating the rate of pay and hours worked per week
 - Most recent year's tax return (an IRS transcript form 4506-T may be required) and all schedules if self employed or receive rental or farm property income)
 - Award Letter
 - OWF
 - Child support and/or alimony receipts
 - Unemployment
 - Worker's Compensation
 - SSI/SSDI
- Proof of household size and dependency
 - Birth certificates or court documents for dependant children
 - Proof of address for ALL adults over the age of 18
 - Notarized Zero Income affidavit for all adults over the age of 18
 - Power of attorney for dependant adults with Zero income
- Proof of current address
 - Utility or phone bill
 - Bank or credit card statement
 - Personal and Bulk mail are NOT sufficient
- Government Issued Photo ID (**any** state, federal, or local government OR public university or school)

* If the income you report is less than 90% of the federal poverty guidelines a denial letter from Medicaid may be required in order to process the application

* If you report ZERO income you must provide a notarized Zero Income affidavit and a notarized statement from whoever is assisting you with living expenses AND IRS form 4506-T. This does not necessarily make that person responsible for your medical care or require their proof of income.

Based on the 2011 Federal Poverty Guidelines

Household Size	Maximum income to be considered for sliding fee
1	\$ 21,660.00
2	\$ 29,140.00
3	\$ 36,620.00
4	\$ 44,100.00
5	\$ 51,580.00
6	\$ 59,060.00
7	\$ 66,540.00
8	\$ 74,020.00

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Financial Assistance Program Application

Patient Name _____ Social Security No. _____

Date of Birth _____ Resident of Ohio? Yes No

Household Members (including yourself) – use the back of this page to list more household members if needed				
Name	Social Security Number	Date of Birth / Age	Relation to the applicant	Current patient at HOFHC?
		/	SELF	<input type="radio"/> Yes <input type="radio"/> No
		/		<input type="radio"/> Yes <input type="radio"/> No
		/		<input type="radio"/> Yes <input type="radio"/> No
		/		<input type="radio"/> Yes <input type="radio"/> No
		/		<input type="radio"/> Yes <input type="radio"/> No
		/		<input type="radio"/> Yes <input type="radio"/> No

INCOME INFORMATION FOR ALL HOUSEHOLD MEMBERS LISTED					
Monthly Income Sources	Applicant	household member 1	household member 2	all others	Total
Employment Income (per month)	\$	\$	\$	\$	\$
Social Security (per month)	\$	\$	\$	\$	\$
SSI, SSDI, &/or BWC (per month)	\$	\$	\$	\$	\$
Unemployment (per month)	\$	\$	\$	\$	\$
Spousal/Child Support (per month)	\$	\$	\$	\$	\$
Rental Property (per month)	\$	\$	\$	\$	\$
Investment Income (per month)	\$	\$	\$	\$	\$
Trust/Settlement (per month)	\$	\$	\$	\$	\$
Other[s] (per month)	\$	\$	\$	\$	\$
Total Monthly Income	\$	\$	\$	\$	\$

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Patient Name _____ Social Security No. _____

Date of Birth _____

I understand that my minimum co-payment is due each visit at the time services are rendered. I understand that any additional services not covered under the minimum co-payment will be billed to me. I understand that if my account balance becomes more than \$100.00 for longer than 60 days I may be removed from the financial assistance program and suspended from the practice.

I understand that I must re-verify my financial and household information 11 months from today's date. It is my responsibility to provide all required documents at that time. Failure to do so will result in an increased cost to me for my medical care. I also acknowledge that my minimum co-payment may change each time I re-verify my information.

I also acknowledge that approval of financial assistance does not imply a contract between me and Heart of Ohio Family Health Centers and that my level of assistance is subject to change at the discretion of the organization.

I certify that all information is valid and complete and hereby authorize Heart of Ohio Family Health Centers to verify any of the above information as deemed necessary which may include obtaining a consumer and/or credit report.

Applicant Signature	Date
Witness Signature	Date

Below is for office use only			
total household size		total household income	\$
assistance category			
Minimum co-pay due each visit	\$	Renewal Date	
application reviewed by	date		