UC Health

Dear Patient:

Plain Language Summary of the Financial Assistance Policy: It is the policy of UC Health to provide financial assistance to patients in need. UC Health will extend medically necessary services at no cost, or at a reduced amount, to an individual who is eligible under the financial assistance policy (FAP). A copy of the FAP can be request by calling (513) 585-6200 or (800) 277-0781 or you can visit our website at http://uchealth.com/financial/financial-assistance/ for downloadable copies. In accordance with the law, UC Health will always provide medical screening and necessary stabilizing treatment to patients in a hospital emergency department even if they can't demonstrate the ability to pay for that care.

Financial Assistance Eligibility: UC Health provides full or partial financial assistance to persons whose family income is at or under the income guidelines listed below. Patients eligible for financial assistance will not be charged more for medically necessary care than the amounts generally billed (AGB) to patients who have insurance.

Eligibility depends upon meeting:

- Cooperation with applying for Medicaid
- Being deemed ineligible for Medicaid
- Income qualifications as outlined below
- Residency

Applying for Financial Assistance: UC Health's Financial Assistance Policy (FAP) documents (including the policy, summary, and application) are available on our website at http://uchealth.com/financial/financial-assistance/ and free paper copies are available in the hospital's emergency room and registration areas. A free copy of the documents can also be requested by mail by calling the phone numbers listed below. Copies of this summary and the financial assistance application are available in English and Spanish.

To determine if you may be eligible for available financial assistance programs, you must provide a completed Financial Assistance Application, along with a copy of one (1) of the documents from each category listed on the back of this letter as soon as possible. Upon receipt, we will process your application and notify you of our determination.

Family Size	Federal Poverty Guidelines	Max Income for 100%	Max Income for 75%
1	$12,760	$19,140	$25,520
2	$17,240	$25,860	$34,480
3	$21,720	$32,580	$43,440
4	$26,200	$39,300	$52,400
5	$30,680	$46,020	$61,360
6	$35,160	$52,740	$70,320
7	$39,640	$59,460	$79,280
8	$44,120	$66,180	$88,240

For family units of more than 8 persons, add $4,480 for each additional person to determine Federal Poverty Guideline. Guidelines are as published by US Health & Human Services in the Federal Registry.

Mailing Address for FAA Applications & Supporting Documentation:

UC Health
Patient Financial Services – Correspondence Unit
3200 Burnet Ave.
Cincinnati, OH 45229-9983

Financial assistance is not health insurance and does not meet the criteria for health insurance as defined by the Affordable Care Act. Financial assistance approvals are valid only for balances not covered by a third party. Financial assistance does not cover balances resulting from your failure to follow through with requests for information from your insurance company or failure to cooperate with the Medicaid application process.

Medicaid recipients are not eligible for financial assistance. Financial assistance cannot be used to cover services if you receive Medicaid coverage through an insurance company that is not in network for UC Health.

If you have any questions, please call (513) 585-6200 or (800) 277-0781. If you believe you are not eligible for financial assistance under the above programs, Customer Service can discuss other program qualifications or payment arrangements with you at that time.

Thank you for choosing UC Health for your medical care.

All patients/guarantors who receive a Financial Statement application must complete and return the application, along with the following documents that serve as the minimum information necessary to process an application for financial assistance. UC Health reserves the right to request additional documentation before finalizing a request for assistance:

Proof of Income	Proof of Residency
If you are claiming that you have no income, a sworn statement from the person providing you with basic financial support, validating your lack of income must be completed.	Driver's license or vehicle registration - matching your current address.
Check stubs for three months prior to the date of service (including payroll, Social Security, Worker's Compensation, unemployment compensation, etc.) or comparable payment record. If you are self-employed, please send a notarized statement of income and expenses for the three-month period prior to the date of service.	Letter from lease management, mortgage company, or person providing the patient with shelter, including homeless shelters.
A letter from your employer setting forth compensation details on official employer letterhead with contact information.	Rent receipts for rent paid within 60 days of when the services are rendered.
Court support order.	Mortgage statement.
Copy of benefit letter / check (ex. Social Security Benefit Letter).	Utility bill, credit card bill or bank statement postmarked or dated by the issuer within 60 days of when the services are rendered.
Letter from tenant setting forth rental income.	Copy of most recent Hamilton County property tax bill.
Strike pay.	Voter registration.
We DO NOT accept tax returns, bank statements, Forms 1099, Forms W-2, etc. as proof of income.	Confirmation of address if a home visit is made by hospital staff.

UC Health

APPLICATION FOR FINANCIAL ASSISTANCE

University of Cincinnati Medical Center ☐ **West Chester Hospital** ☐ **Daniel Drake Center** ☐ **University of Cincinnati Physicians** ☐

PLEASE PRINT:

Today's Date: ____ / ____ / ____ (Month / Day / Year) Med Rec # ____ Account # ____

Patient Name: ____ (Last) ____ (First) ____ (M.I.)

Responsible Party, if not Patient: ____ (Last) ____ (First) ____ (M.I.)

Patient Address: ____ (Street) ____ (Apt. #)

____ (City) ____ (County) ____ (State) ____ (Zip)

Home Phone: ___ - ___ - ____ (Area Code) **Work Phone:** ___ - ___ - ____ (Area Code)

Email Address: ____

Patient Social Security Number: ___ - ___ - ____

Patient Date of Birth: ____ / ____ / ____ (Month / Day / Year) **Date of Service:** ____ / ____ / ____ (Month / Day / Year)

Please list all family members (including you). Family members include the applicant, their spouse* and children (natural or adoptive) under the age of 18 living in the home along with the applicant. Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security benefits, public assistance, etc.

Family Members	Age	Relationship to Patient	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service
1.					
2.					
3.					
4.					
5.					
6.					

*****The State of Ohio does not have a legal distinction of "legally separated" for married couples. Until a final decree of divorce, annulment, dissolution, etc. is granted a separated couple is the same as a married couple and the spouse must be included as a family member.

UC HEALTH
APPLICATION FOR FINANCIAL ASSISTANCE

Were you an Ohio resident at the time of your hospital service?	**Yes**		**No**	
Were you a United States citizen at the time of your hospital service?	**Yes**		**No**	
Did you have health insurance at the time of your hospital service?	**Yes***		**No**	
Were you an active recipient of Disability Assistance or Medicaid at the time of your hospital service?	**Yes***		**No**	

** If you answered "Yes" to either of the above two insurance questions, please attach a copy of your insurance card (front and back), Medicaid or Disability Assistance card to this application and complete the following:*

Name of Insurance Company:

If you reported $0.00 income above, please have the Support Statement below completed by the person(s) helping to support you and/or your family.

Policy Number: **Group Number:**

Insurance Phone Number: **Medicaid or Disability Assistance Number:**

SUPPORT STATEMENT

For applicants who stated zero income, the person(s) providing you with basic financial support must provide a brief explanation as to how you are being financially supported. List services, if any, that you are receiving from patient for providing this support.

_____

_____

_____

_____

I hereby certify and verify that all of the foregoing information given is true and correct to the best of my knowledge and belief. I understand that my signature does not obligate me to be financially responsible for charges rendered to the person for whom I am providing basic financial support.

_____ _____
Signature of person providing financial support to applicant **Address**

_____
City, State Zip

By my signature below, I certify that I have carefully read this application and that everything I have stated or provided in any attachment is true and correct to the best of my knowledge and belief. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Patient/Guarantor Signature: _____ **Date Completed:** _____

If you have questions or need assistance with this application, please call **513-585-6200** or **1-800-277-0781** or visit our website http://uchealth.com/financial/financial-assistance/.