NATIONWIDE CHILDREN'S HOSPITAL
FINANCIAL ASSISTANCE PROGRAMS

HEALTHY START AND HEALTHY FAMILIES

Call 614-722-9133 or 1-888-851-7590

Healthy Start and Healthy Families offer free and low cost health care coverage to families, children (up to age 19) and pregnant women. Coverage includes doctor visits, hospital care, pregnancy related services, medicine, vision, dental, substance abuse, mental health services and much more. Healthy Start is designed to keep working families working.

Qualifications:

Healthy Start for Children at or below 200% of the Federal Poverty Level (FPL)
Healthy Start for Pregnant Women at or below 150% Federal Poverty Level (FPL)
Healthy Families at or below 100% at Federal Poverty Level (FPL)
Children and families with incomes between 151% - 200% of the federal poverty levels cannot have creditable health insurance at time of application to be eligible for Healthy Start.

HOSPITAL CARE ASSURANCE PROGRAM (HCAP)

Call 614-722-2055

**** See back of this page for an application ****

HCAP is Ohio's version of the federally required Disproportionate Share Hospital Program. It provides hospital service support for persons whose income falls below 100% poverty, and who are not Medicaid eligible. This program is for the hospital bill only. All insurance and third party payers must be billed before applying for HCAP. Aid may only be given for the part of the bill that is patient's responsibility.

Qualifications:

At or below the federal poverty level
Cannot be a recipient of Medicaid
A resident of the state of Ohio

PAYMENT ARRANGEMENTS

Call 614-722-2055

If you are unable to pay your bill in full, please call the Nationwide Children's Hospital Patient Accounts Department to set up payment arrangements.

FINANCIAL ASSISTANCE PROGRAM

Call 614-722-2055

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Nationwide Children's Hospital expects patients to use all other available resources, including application to the local Department of Job and Family Services, before financial assistance will be considered. Eligibility for assistance is based upon total gross income \ assets and the number of dependents in the family. Cases that are unusual or extraordinary will also be taken into consideration.

2013 POVERTY INCOME GUIDELINES

Family Size	Income 100% FPL	Income 150% FPL	Income 200% FPL	Income 300% FPL	Income 400% FPL
1	$11,490	$17,235	$22,980	$34,470	$45,960
2	$15,510	$23,265	$31,020	$46,530	$62,040
3	$19,530	$29,295	$39,060	$58,590	$78,120
4	$23,550	$35,325	$47,100	$70,650	$94,200
5	$27,570	$41,355	$54,140	$82,710	$110,280
6	$31,590	$47,385	$63,180	$94,770	$126,360
7	$35,610	$53,415	$71,220	$106,830	$142,440
8	$39,630	$59,445	$79,260	$118,890	$158,520
For each additional person, add	$4,020	$6,030	$8,040	$12,060	$16,080

NATIONWIDE CHILDREN'S HOSPITAL

HCAP and Financial Assistance Program Application

Place Registration Sticker Here

Patient Name:	Guarantor Name:
Address, City and State:	Phone Number:

1) Was the patient a resident of Ohio at the time of service? Yes____ No____
2) Was the patient a citizen of the United States at the time of service? Yes____ No____
3) Did the patient have Medical Insurance at the time of service? Yes____ No____
4) Was the patient an active Medicaid recipient at the time of service? Yes____ No____
5) Was the patient an active recipient of Disability Assistance at the time of service? Yes____ No____

If you answered **yes** to question 3, 4, or 5 please **attach a copy** of your insurance, Medicaid, or DA card to this application.

Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, etc.
Family members include all listed below regardless of where they live.

Family Member's Name	Age	Date of Birth	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
			Patient			
			Mother			
			Father			

Please check income verification attached:

☐Copies of Pay Stubs ☐All W-2's for Household or 1099's

☐Income Tax Return ☐Unable to Provide

If you reported $0 income, please provide a brief explanation of how you (or the patient) are surviving financially:

_____

_____

_____

By my signature below, I certify that everything that I have stated on this application and on my attachments is true.

_____
Applicant's signature

_____
Date

Return this form with any attachments to:

Nationwide Children's Hospital
Patient Accounts – F.A. Dept
700 Children's Drive
Columbus, OH 43205
614-722-2055
Fax to: 614-355-2266