NATIONWIDE CHILDREN'S HOSPITAL
PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY (FAP)

FINANCIAL ASSISTANCE PROGRAM

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

Nationwide Children's Hospital provides free or discounted care for basic, medically necessary services to individuals qualifying for the Financial Assistance Program or Hospital Care Assurance Program (HCAP). Patients must use all other 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 (how much you make before taxes) and the number of dependents in the family. Eligible patients will not be charged more for emergency or other medically necessary care than amounts generally billed (AGB) to those patients who have insurance.

Qualifications:

At or below 400% of the federal poverty level

Cannot be a recipient of Medicaid – Medicaid recipients who receive Medically Necessary Care not covered Medicaid will be covered by the Financial Assistance Program.

Live in the State of Ohio - Non-Ohio residents requesting financial assistance for non-emergent medical care must be pre-approved for financial assistance before receiving care.

NEED HELP APPLYING FOR FINANCIAL ASSISTANCE?

Call 614-722-2055

See any Patient Access Representative at 700 Children's Drive or at any of our other locations for help or to get a free copy of the FAP, Plain Language Summary of the FAP, and Financial Assistance Application in English or other languages. You may also visit www.NationwideChildrens.org/Financial-Assistance for these documents.

HOSPITAL CARE ASSURANCE PROGRAM (HCAP)

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

HCAP is Ohio's version of the federally required Disproportionate Share Hospital Program. This program is for the hospital bill only. All insurance and third party payers must be billed before applying for HCAP. Assistance may only be given for the part of the bill that the patient has to pay.

Qualifications:

At or below the federal poverty level

Cannot be a recipient of Medicaid

Live in the State of Ohio

HEALTHY START AND HEALTHY FAMILIES

Call 614-722-2070 or 1-800-324-8680

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.

Qualifications:

Healthy Start for uninsured children in families with income up to 206% of the Federal Poverty Level (FPL)

Healthy Start for insured children in families with income up to 156% of the Federal Poverty Level (FPL)

2019 POVERTY INCOME GUIDELINES

Family Size	Income 100% FPL	Income 150% FPL	Income 200% FPL	Income 300% FPL	Income 400% FPL
1	$12,490	$18,735	$24,980	$37,470	$49,960
2	$16,910	$25,365	$33,820	$50,730	$67,640
3	$21,330	$31,995	$42,660	$63,990	$85,320
4	$25,750	$38,625	$51,500	$77,250	$103,000
5	$30,170	$45,255	$60,340	$90,510	$120,680
6	$34,590	$51,885	$69,180	$103,770	$138,360
For each additional person, add	$4,420	$6,630	$8,840	$13,260	$17,680

NATIONWIDE CHILDREN'S HOSPITAL
HCAP and Financial Assistance Application

Place Registration Sticker Here

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

1) Was the patient living in 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 ☐Letter from employer

☐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