Application for Financial Assistance Program

FCHC Medical Care, LLC

Thank you for choosing FCHC Medical Care, LLC for your healthcare needs.

This application is for Financial Assistance for services rendered at FCHC Medical Care, LLC which includes: Delta Medical Center, Fayette Medical Center, FCHC Hospitalists, FulCare Outpatient Clinic, Fulton County OB/GYN, Oncology Clinic, West Ohio Family Physicians, West Ohio Orthopedics, West Ohio Pediatrics, and West Ohio Surgeons.

2019 FEDERAL POVERTY GUIDELINES	
FAMILY SIZE	**INCOME**
1	12,490
2	16,910
3	21,330
4	25,750
5	30,170
6	34,590
7	39,010
8	43,430
For families/households with more than 8 persons, add $4,420 for each additional person.	

Required for Processing:
All questions must be answered.
List all family members, ages, and relationship to patient living in household.
All income lines must be completed (include 3 and/or 12 months) prior to the date of service.
If zero income is reported you must include a statement of how you are financially surviving.
The application must be signed and dated by the patient unless the patient is a dependent, deceased or has a POA.

Your prompt response in completing and returning your financial application will help avoid future billings and/or potential collection activity.

Please call us at 419-337-7451 with any questions. We are available for calls Monday through Friday from 8:00 am until 4:30 pm.

You may drop your completed application off at any of our offices or mail it to:

FCHC Medical Care, LLC
735 South Shoop Avenue
Wauseon, Ohio 43567

APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM
FCHC Medical Care, LLC

Patient Name		Date	
Guarantor Name		Contact #	
Street Address		Email	
City / State / Zip		County	

Were you or any family member an **active Medicaid recipient** on date of service? Circle One: Yes No

If ***Yes,*** enter **Medicaid recipient ID number**

Did you or a family member have health insurance on date of service? Circle One: Yes No

If ***Yes*** *:* Insurance Name:
Policy Holder:
Policy#

Please provide the following information for all of the people in your immediate family who live in your home. A family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s)' children under 18 (natural or adoptive) who live in the patient's home.

Name	Age	Relationship to Patient
Total Persons in Family:		

Total family GROSS income for 3 months prior to date of service	$
Total family GROSS income for 12 months prior to date of service	$

If reporting $0 income, please provide a brief explanation below as to how you (the patient) are surviving financially.

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

X____ Date:____________________

(Applicant Signature)