

# 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. Eligibility for financial assistance applies to all patients regardless of race, color, creed, ethnicity, national origin, age, sex, sexual orientation, gender identity, religion, or disability.

#### **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 by 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](http://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)

### **2023 POVERTY INCOME GUIDELINES**

Family Size	Income 100% FPL	Income 150% FPL	Income 200% FPL	Income 300% FPL	Income 400% FPL
1	\$14,580	\$21,870	\$29,160	\$43,740	\$58,320
2	\$19,720	\$29,580	\$39,440	\$59,160	\$78,880
3	\$24,860	\$37,290	\$49,720	\$74,580	\$99,440
4	\$30,000	\$45,000	\$60,000	\$90,000	\$120,000
5	\$35,140	\$52,710	\$70,280	\$105,420	\$140,560
6	\$40,280	\$60,420	\$80,560	\$120,840	\$161,120
For each additional person, add	\$5,140	\$7,710	\$10,280	\$15,420	\$20,560

# NATIONWIDE CHILDREN'S HOSPITAL

## HCAP and Financial Assistance Application

Place Registration Sticker Here  
OR  
Date of Service: \_\_\_\_\_

A separate application **MUST** be submitted for each patient

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			
			Parent			
			Parent			

**Please check income verification attached:**

- Copies of Pay Stubs     Letter from employer  
 Unable to Provide

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
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**  
**Email us at:**  
 Children'sPatientAccounts@NationwideChildrens.org