HOSPITAL FINANCIAL ASSISTANCE PROGRAM

Lima Memorial HEALTH SYSTEM
Affiliate of ProMedica

DIRECTIONS FOR COMPLETING THIS APPLICATION:

Please complete all fields, and sign where indicated. Please provide all types of gross family income, such as employment, unemployment compensation, social security, pensions, self-employment, disability, workers compensation, alimony, child support, etc. **You must reside within one of the ten counties listed below for HFA.**

PLEASE NOTE, ALL INFORMATION PROVIDED IS CONFIDENTIAL AND IS ONLY USED FOR THE PURPOSE OF DETERMINING YOUR DISCOUNT. THIS APPLICATION IS ONLY FOR HOSPITAL SERVICES.

Ohio hospitals are required by law to provide medically necessary hospital services free of charge to any eligible person. If you meet the Federal Poverty Guidelines (see the chart), fill out this form and return it to the Patient Accounts office at Lima Memorial.

Annual income must be at or below the following amounts according to family size:

INCOME STATUS COMPARED TO 2018 FEDERAL POVERTY LEVELS UP TO

Federal Guidelines	100%	200%	Without Insurance 200%+	401%
FAMILY INCOME LEVEL ($) (Not to exceed)				
Family Size	HCAP	HFA	HFA	HFA
1	$12,140	$24,280	$24,281	$48,681
2	$16,460	$32,920	$32,921	$66,005
3	$20,780	$41,560	$41,561	$83,328
4	$25,100	$50,200	$50,201	$100,651
5	$29,420	$58,840	$58,841	$117,974
6	$33,740	$67,480	$67,481	$135,297
7	$38,060	$76,120	$76,121	$152,621
8	$42,380	$84,760	$84,761	$169,994
Discount off charges	100% HCAP	100% HFA	95% HFA	58% HFA

For families / households with more than 8 persons, add $4,180 for each additional person.

Check the Ohio county you reside in :

- ☐ **Allen**
- ☐ **Auglaize**
- ☐ **Hancock**
- ☐ **Hardin**
- ☐ **Logan**
- ☐ **Mercer**
- ☐ **Paulding**
- ☐ **Putnam**
- ☐ **Shelby**
- ☐ **Van Wert**

Patient Name _____ **Date of Service** ___/___/___
First Middle Initial Last Not application date

Address _____ **Social Security No.** _____
Street City State Zip Code

Phone _____ **Email** _____
Provide if you would like to receive communication regarding this application via email.

Date of Birth ___/___/___ **Gender** _____ **Marital Status** Single ☐ Married ☐ Divorced ☐ Widowed ☐

Are you a citizen of the United States? **Yes** ☐ **No** ☐ If not a U.S. citizen, what is your student / work VISA # _____

Do you have health insurance covering these services? **Yes** ☐ **No** ☐ Please attach a copy of the card.

Do you have Medicaid benefits for this date of service? **Yes** ☐ **No** ☐

Have you applied for Medicaid within the last year? **Yes** ☐ **No** ☐ Please provide proof of denial from Medicaid.

Medicaid Billing # _____ Do you have Disability Assistance Benefits? **Yes** ☐ **No** ☐
Please attach a copy of the card.

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If auto related, do you have auto insurance covering this date of service? **Yes** ☐ **No** ☐

If yes, what is the insurance company name? _____

Adjuster Name _____ **Phone** _____

Please provide the following information for yourself and your immediate family members that live in your home. For the purpose of this application, family is defined as the patient, patient's spouse and natural or adopted children, younger than 18 years old, who live in the patient's home at the date of service. If the patient is younger than 18 years old, please include parent's income. If a child is the patient and receives child support, that income needs to be listed below.

IF THERE IS NO INCOME, PLEASE EXPLAIN HOW THE PATIENT IS SUPPORTING THEMSELVES:

_____

Names	Age	Relationship to Patient	Gross income 3 months prior to date of service	Gross income 12 months prior to date of service	Type of Income
Patient Name		Patient			
Family Members Names					

Please attach an additional page if more family members are to be included.

Totals

PATIENT / GUARANTOR'S EMPLOYER FOR THE LAST 12 MONTHS PRIOR TO DATE OF SERVICE:

Name of Employer _____ **Date Hired** ___/___ **Date Ended** ___/___

Name of Employer _____ **Date Hired** ___/___ **Date Ended** ___/___

SPOUSE / OTHER GUARANTOR'S EMPLOYER FOR THE LAST 12 MONTHS PRIOR TO DATE OF SERVICE:

Name of Employer _____ **Date Hired** ___/___ **Date Ended** ___/___

Name of Employer _____ **Date Hired** ___/___ **Date Ended** ___/___

By signing below, I state that the information on this application is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to verification by Lima Memorial and any financial assistance provided may be reversed if it is determined this information is not correct. Providing false information to induce another to extend credit or bestow any other valuable benefit may be a violation of the Ohio Revised Code Section 2921.13.

Responsible Party's Signature _____ **Date** ___/___

Lima Memorial Patient Accounts | 1001 Bellefontaine Avenue, Lima, Ohio 45804 | 567-242-0460