Bucyrus Hospital - Galion Hospital - Avita Ontario - Avita Physicians

Applicant Name: _____

Family's Street Address: _____

City _____ **State**____ **Zip** _____ **Phone**_____ **Alternate Phone**_____

Date(s) of Service* _____

***Separate applications must be completed for 3-month date ranges (ex: 1/1/17 thru 4/1/17)

Account Number(s) * _____

*Applications will be accepted for dates of service up to 240 days from first statement date.

1. **Is the patient(s) a U.S. citizen?** **Yes**___ **No**___
   If no, explain: _____
2. **Was the patient(s) an Ohio resident at the time of his/her service?** **Yes**___ **No**___
   If no, explain: _____
3. **Was the patient(s) an active Medicaid or Disability Assistance recipient at the time of his/her service?** **Yes**___ **No**___
   If yes, Medicaid recipient ID number(s): _____; _____; _____
4. **Did the patient(s) have health insurance (other than Medicaid) at the time of his/her service?** **Yes**___ **No**___
   If yes, provide name of insurance: _____
5. **Did the patient(s) or any family member whose health insurance coverage would have covered the patient decline health insurance within the previous 12 months?** **Yes**___ **No**___
   If yes, explain the reason for declining coverage: _____

Provide all of the required information for applicant and everyone who lives in his/her home.

Full Name	Birth Date	Relationship to Applicant	Total Gross Income *Provide details on the Income Verification Checklist*	
			3 months before the oldest date of service	12 months before the oldest date of service

Completed and signed INCOME VERIFICATION CHECKLIST (form attached) and the supporting DOCUMENTATION are REQUIRED to process your application

If you report $0 or minimal income, provide a brief explanation on the back of this form or attached income checklist on how you are meeting basic living needs, including who provides shelter, food, transportation, utilities, clothing and how long you have been supported by this person(s) and/or agency(s).

By my signature above, I certify that I have or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding any situation, I am subject to possible prosecution for fraud. By signing this application, I am authorizing the release of any information needed to determine my eligibility, not to exclude address verification, a credit check through a national credit bureau, asset check through the County Tax Assessor, and verification of all benefits listed.

Signature_____Date____/_____/_____

Return application to: Financial Counselor, Avita Health System, 269 Portland Way South, Galion, OH 44833

Call our Customer Service Line with questions or to request assistance completing the application: 419-468-0512

Family Definition – Patient 18 Years of Age or Older	HCAP	Avita Financial Assistance Program
Patient	X	X
Patient's spouse, regardless of whether or not he/she lives in the home	X	X
Patient's children under 18, natural or adoptive who live in the home	X	X
Any person who is providing more than 50% of funding required for the patient's living expenses, regardless of whether or not he/she lives in the home with the patient		X
Any person living in the home with the patient who is dependent on the patient's family income for over 50% of their support		X

Family Definition – Non-married, Un-emancipated Patient 17 Years of Age or Younger	HCAP	Avita Financial Assistance Program
Patient	X	X
Patient's natural or adoptive parent(s), regardless of whether they live in the home	X	X
The parent(s)' children, natural or adoptive under the age of 18 who live in the home	X	X
Any person who is providing more than 50% of funding required for the patient's living expenses, regardless of whether or not he/she lives in the home with the patient		X
Any person living in the home with the patient who is dependent on the patient's family income for over 50% of their support		X

Income Guidelines – 2019 – HCAP Program

Free Care for Patients with Income Below the Federal Poverty Guideline

Family Size	**2019** Annual Family Income
1	Less than $12,490
2	Less than $16,910
3	Less than $21,330
4	Less than $25,750
5	Less than $30,170
Each Additional Family Member	Add $4,420

Income and Asset Guidelines – 2019 – Avita Financial Assistance Program

Sliding Scale Based on Income and Liquid Assets up to 400% of the Federal Poverty Guideline

Family Size	**2019** Annual Family Income etc.	
1	$ 12.491	$ 49,960
2	$ 16,911	$ 67,460
3	$ 21,331	$ 84,956
4	$ 25,751	$ 102,456
5 or more	$ 30,171	$119,952

Applicant Name: _____
Date of Application: _____

INCOME VERIFICATION CHECKLIST

Medicaid/Presumptive Medicaid *(information needed)*

- o Income verification
- o Family size reported on your tax return
- o Names, income, and birth dates for everyone living in your home but not reported on your tax return

Avita Financial Assistance *(required information and documentation)*

INCOME (all family members)	Circle One	Amount	Required Documentation
Wages	Yes or No	$_____	Pay Stubs/W-2's
Social Security	Yes or No	$_____	Award Letter
Veterans Benefits	Yes or No	$_____	VA Benefit Letter
SSI	Yes or No	$_____	Award Letter
Railroad Benefits	Yes or No	$_____	Award Letter
Self-Employment Income	Yes or No	$_____	1040/Schedule C
Retirement/Pension Benefits	Yes or No	$_____	Benefit Letter
Child Support or Alimony	Yes or No	$_____	Court Documentation
Food Stamps	Yes or No	$_____	Award Letter
Unemployment Compensation	Yes or No	$_____	Unemployment Printout
Income from Rent	Yes or No	$_____	Check or receipt copy
Income from Dividends/Interest/Royalties	Yes or No	$_____	Earnings Statement
Military Family Allotments	Yes or No	$_____	Paycheck Allotment
Income from Estates/Trusts	Yes or No	$_____	Earnings Statement
IRA/401K/401B Annuity Payments	Yes or No	$_____	Bank or Earnings Statement
Support from Relatives/Friends	Yes or No	$_____	Written Statement
Farm Income	Yes or No	$_____	1040/Schedule C
Workers Compensation.	Yes or No	$_____	BWC Award Letter
Parenting Plan	Yes or No	$_____	Court Documentation
Network of Care	Yes or No	$_____	Court Documentation
Residential Foster Care	Yes or No	$_____	Court Documentation
Other _____	Yes or No	$_____	Supporting document(s)

LIQUID ASSETS	Circle One	Amount/Value	Required Documentation
Cash	Yes or No	$_____	Patient Attestation
Savings Accounts	Yes or No	$_____	Current Statement
Checking Accounts	Yes or No	$_____	Current Statement
Money Market Accounts	Yes or No	$_____	Current Statement
Stocks/Bonds/Certificates of Deposit	Yes or No	$_____	Current Statement
Trust fund balance	Yes or No	$_____	Current Statement
Lottery winnings within 12 mths of service date	Yes or No	$_____	Supporting document(s)
Other _____	Yes or No	$_____	Supporting document(s)

If you have reported zero or minimal income, please provide a brief explanation on the lines below on how you are meeting basic living needs, including who provides shelter, food, transportation, utilities, clothing and how long you have been supported by this person(s) and/or agency(s).

Comments – Please provide any additional information or comments regarding your financial situation and/or your current liabilities.

By my signature below, I certify that I have or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding any situation, I am subject to possible prosecution for fraud. By signing this application, I am authorizing the release of any information needed to determine my eligibility, not to exclude address verification, a credit check through a national credit bureau, asset check through the County Tax Assessor, and verification of all benefits listed.

Signature: _____ **Date:** _____

AVITA HEALTH SYSTEM – COLLECTION POLICY
(PLAIN LANGUAGE STATEMENT)

Avita Health System – Galion, Bucyrus, and Ontario Hospitals and our Avita Physicians are dedicated to providing the highest quality and most cost effective care. All patients shall be admitted to the hospital for urgent and emergent care without discrimination based on race, color, creed, national origin, sex, age, disability, sexual orientation, or ability to pay.

Our Avita team will bill your insurance carrier based on information you provide during the scheduling and registration process. If your claim is not paid, you should contact your insurance company promptly to resolve any issues. Our Customer Service team and Patient Billing Advocates are available to answer any questions you may have or assist you in contacting your insurance company.

All patients will be billed directly and timely, receiving a series of communications from Avita Health System. Patient statements and letters include a financial assistance application along with phone numbers. Detailed information regarding our financial assistance and collection policies is available at www.avitahealth.org or by contacting our Customer Service team. If reasonable attempts to resolve a past due patient balance using these methods are not successful within 120 days, the account will be referred to an outside collection agency.

FINANCIAL ASSISTANCE AVAILABLE

If you are financially unable to pay, we want to help you apply for available assistance programs, which includes Ohio's Hospital Care Assurance Program (HCAP). Through HCAP, Avita provides basic, medically necessary hospital services free of charge to Ohio residents whose income falls below the HCAP guidelines. If your income exceeds HCAP guidelines but your income, savings, and/or assets are limited or your extensive medical bills do not allow you to pay for your services, please contact us to see if you qualify for other financial assistance. Standardized criteria are used based on total gross family income and the number of dependents in the family unit. The Federal Poverty Guidelines in effect on the service date are the basis for determining the income guidelines and eligibility. We encourage all eligible patients to apply and provide information through discussions during scheduling, registration, financial counseling, and billing conversations. Avita publishes information and guidelines on signage, on our statements and provides information to community action groups. Copies of Avita's financial assistance policy and applications will be provided free of charge.

Financial assistance requests can be made by contacting the Customer Service team via telephone or written correspondence, or by visiting the Financial Counseling team located at both Galion and Bucyrus Community Hospitals. Applications are available:

- On our Website (www.avitahealth.org) along with a comprehensive description of Avita's financial assistance policy and instructions for completing the application;
- On the back of your first Avita statement;
- By calling our Avita Customer Service team to request an application be mailed to you; or
- From your Avita physician office, hospital registration area, or Cashiers Office.

Completed applications and supporting documentation can be mailed to a Financial Counselor at the address listed below. Or, you may bring your completed application and supporting documentation to any Avita location. Avita will not refer accounts to a collection agency if the patient's initial financial assistance application has not yet been processed and the patient has not yet been notified of the determination.

CHARGES WILL NOT EXCEED AMOUNTS GENERAL BILLED (AGB)

If you receive an award of financial assistance, your patient responsibility amount for emergency or other medically necessary care will not exceed the amount generally billed (AGB) by Avita. For a comprehensive explanation of how Avita calculates their AGB, visit www.avitahealth.org.

COLLECTION ACTIVITY AND EXTRAORDINARY COLLECTION ACTIONS (ECAs)

Patient balances may be referred to a third party for collection at the discretion of Avita Health System. Ownership of the debt will be maintained by Avita Health System.

Patient balances will only be referred to a collection agency if, to the best of the Avita staff's knowledge:

- There is a reasonable basis to believe the patient owes the debt.
- All third-party payers have been properly billed, and the remaining debt is the financial responsibility of the patient.
- The open balance is the patient liability amount and does not relate to a claim that was denied due to an Avita Health System error.
- The patient or responsible individual has not submitted a complete financial assistance application within the required timeframe.

Collection activity will include telephone calls, collection mailings, personal interviews and other appropriate contacts.

If a patient or other responsible party fails to resolve an outstanding balance by applying for financial assistance and/or making payment within 240 days from the first post discharge statement, Avita may authorize the collection agency to take any of the following extraordinary collection actions (ECAs) to obtain payment for care:

- Report adverse information to the credit bureaus; or
- Refer the outstanding balance to an attorney for review to commence a civil action, obtain judgment, and file wage garnishments, bank garnishments, or judgment liens, as necessary and appropriate.

IMPORTANT CONTACT INFORMATION

Customer Service Line: 419-468-0512 Patient Billing Advocates: 419-462-4502

Written communication address: Financial Counseling Team * Avita Health System * 269 Portland Way South * Galion, OH 44833

Compliance with Federal Civil Rights Laws

Avita Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avita Health System does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avita Health System:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please inform your Admitting Clerk or contact Cinda Kropka, Civil Rights Coordinator at 419.468.0571.

If you believe that Avita Health System has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Cinda M. Kropka, Compliance/Ethics & Privacy Director & Civil Rights Coordinator, 269 Portland Way S, Galion OH 44833, 419.468.0571, Fax 419.468.0721, or email ckropka@avitahs.org. You can file a grievance in person or by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 419-468-4841.

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ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 419-468-4841.

مكبلاو مصلا فتاه 4841-468-419 :قطوحلم اذإ تدحتت تنك اذا ركذا ةغلا قدعاسملا تامدخ نإف ،ناجملاب كل رفاوتت قيوغلا قدعاسملا تامدخ نإف ،ةغلا ركذا ثدحتت تنك اذإ :قطوحلم 4841-468-419 مكبلاو مصلا فتاه.مقرب لصتا.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 419-468-4841.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 419-468-4841.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 419-468-4841.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 419-468-4841.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 419-468-4841.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 419-468-4841 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 419-468-4841.

□□□□ : □□□□ を□ される□□ 、□□ の□□□□□ をご□□ いただけます。419-468-4841 まで、お□□ にてご□□ ください。.

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 419-468-4841.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 419-468-4841.

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 419-468-4841.