Dear Patient:

Aultman Alliance Community Hospital (AACH) provides medically necessary care without charge, or at a reduced rate, to patients who cannot afford to pay. To be eligible, patients must complete a financial assistance application and family income must be at or below 300% of the federal poverty level income guidelines. Federal poverty guidelines are updated annually by the Department of Health and Human Services.

Income Guidelines as of **January 15, 2020**:

Size of Family	Maximum Income For Care at 100% Reduction - No Cost	Maximum Income For Care at 75% Reduction	Maximum Income For Care at 53% Reduction
1	$12,760	$25,520	$38,280
2	$17,240	$34,480	$51,720
3	$21,720	$43,440	$65,160
4	$26,200	$52,400	$78,600
For each additional family member add			
	$4,480	$8,960	$13,440

AACH will not engage in extraordinary collection actions (ECA), either directly or by any debt collection agency to which the hospital has referred the patient's debt, before reasonable efforts are made to determine whether a responsible individual is eligible for assistance under the hospital's financial assistance program. ECA means any action against an individual responsible for a bill related to obtaining payment on a self-pay account that requires a legal or judicial process or reporting adverse information about the responsible individual to consumer credit reporting agencies/credit bureaus. ECAs do not include transferring of a self-pay account to another party for purposes of collection without the use of any ECAs.

In order to be considered for financial assistance:

1. Fill out the enclosed application, date and sign
2. Provide proof of income for the 3 months prior to the date of service
3. Proof of income can be verified with copies of tax returns, W-2s, check copies or bank statements
4. Family size includes parents, spouses and children (natural or adopted) under the age of eighteen (18) living in the home
5. Financial assistance is only available for services at Aultman Alliance Community Hospital. Professional fees are not included.

Mail all information and application to:

Aultman Alliance Community Hospital
Attn: Credit Department
200 East State Street
Alliance, OH 44601

Questions regarding financial assistance should be directed to the Patient Financial Services at 330-596-7584 between the hours of 8 a.m. and 4 p.m. Monday through Friday. To request a copy of the hospital's financial assistance policy and an application form, please contact Patient Financial Services or visit our website under the Patient Resources section at www.aultmanalliance.org.

Aultman Alliance Community Hospital – Hospital Care Assurance Application

Patient Name:_______________________________________ Medical Rec. #:___________ ID Number______________________________
Address:____ Month of Service:_________ Family Member Interviewed:_________________
City:____ Patient's DOB:____________ Responsible Party:________________________
State:________________ Zip:________________________ Patient's SSN:____________ Relation to Patient:______________________

Do you have health insurance covering these services? Yes [ ] No [ ] If yes, enter information below & attach copy of insurance card
Name of Insurance Company:________________________ Policy #:__________________________ Group #:_____________________
Do you have Medicaid Benefits? Yes [ ] No [ ] If yes, enter billing #:___________________& attach copy of Medicaid card
Do you have Disability Assistance (DA) benefits? Yes [ ] No [ ] If yes, enter billing #___________________& attach copy of DA Card
Please list all "family" members (including yourself). Family members include parents, spouses & children (natural or adoptive) under the age of eighteen (18) living in the home with the parent. Income includes (pretax) wages, rental income, unemployment compensation, Social Security benefits, public assistance, etc.

Family Members	Age	Relation to Patient	Source of Income or Employer Name	Income for 3 months prior to service date	Income for 12 months prior to service date
1.					
2.					
3.					
4.					
5.					
6.					
7.					
Totals					

If you reported $0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested above.

____

I affirm that the answers on this application are true, and I understand that it is unlawful to knowingly submit false information to obtain government benefits.
Responsible Party Signature:____ Date Completed:_______________

By my signature below, I affirm to the best of my knowledge and believe that the answers on this application are true. I further understand and agree that other parties may rely on the information I provide herein. I hereby authorize them to do so.

Hospital Representative Signature:____ Date Completed:_______________

PA-430-QP 6-19 **A new or updated application is required for each month in which services are provided.**