Fulton County Health Center

Thank you for choosing Fulton County Health Center for your healthcare needs.

Enclosed is an application for Financial Assistance for services rendered at Fulton County Health Center. ***Other providers who perform services at Fulton County Health Center, but are not covered under this policy include: Pathology, Radiology, Emergency Room Physicians, Anesthesia, and Wound Care.*

Please be aware that Financial Counselor(s) may request below information in order to process your financial application to best benefit you.

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
Copies of current income and previous year taxes showing adjusted gross income
Do you have an HSA or FSA account? You must provide the most recent statement showing available balance
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/has a POA

Additional Request: (may be requested for additional financial programs)

Applied for Medicaid
Attach current copies of all medical bills (Medical, Prescriptions, Dental and Vision)
Debt to Income
A written Medical and Financial Statement explaining your hardship and why you are requesting Financial Assistance

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

Please call the Financial Counseling Office with any questions, to set up an appointment or for assistance in completing your application. We can be reached Monday - Friday (8am to 4:30pm) by contacting us at **419-330-2669 (option # 2)**.

You may complete and submit your application:

Online: www.fultoncountyhealthcenter.org
Email: cashiers@fulhealth.org
Fax: 419-330-2686
Fulton County Health Center
Attn: Financial Counseling
725 South Shoop Avenue
Wauseon, Ohio 43567

FAMILY SIZE	HCAP	CHARITY
1	15,060	30,120
2	20,440	40,880
3	25,820	51,640
4	31,200	62,400
5	36,580	73,160
6	41,960	83,920
7	47,340	94,680
8	52,720	105,440

DOS 1/16/2024 – 1/16/2025
Add $5,380 for each additional person if the family unit has more than eight members.

FAMILY SIZE	HCAP	CHARITY	300% FPL	400% FPL
1	15,650	31,300	46,950	62,600
2	21,150	42,300	63,450	84,600
3	26,650	53,300	79,950	106,600
4	32,150	64,300	96,450	128,600
5	37,650	75,300	112,950	150,600
6	43,150	86,300	129,450	172,600
7	48,650	97,300	145,950	194,600
8	54,150	108,300	162,450	216,600

DOS 1/17/2025 – Present
Add $5,500 for each additional person if the family unit has more than eight members.

FULTON COUNTY HEALTH CENTER
CASHIER OFFICE
725 SOUTH SHOOP AVENUE
WAUSEON, OH 43567
419-330-2669 option 2

OFFICE HOURS: Monday –Friday 8:00 AM - 4:30 PM

APPLICATION FOR HCAP / FINANCIAL ASSISTANCE PROGRAMS

Patient Name:		Date:	
Guarantor Name:		Contact #:	
Street Address:		Email Addr:	
City / State / Zip:		County:	
Were you an **active Medicaid recipient** at the time of your hospital service? *If **Yes,** enter **Medicaid recipient ID number*** _____			Yes _____ No _____
Did you have health insurance (other than Medicaid) at the time of your service? *If Yes:* Insurance Name:_____Policy Holder:_____Policy#_____			Yes _____ No _____
Were you a resident of Ohio at the time of your hospital service?			Yes _____ No _____

1. Please provide the following information for all of the people in your immediate family who live in your home. For purposes of HCAP, 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	DOB	Age	Relationship to Patient
Total Persons in Family:			

2. Total family GROSS income for **3 months** prior to date of service:	$	$	$	TOTAL: $
3. Total family GROSS income for **12 months** prior to date of service:		thru		TOTAL Income: $
4. Current family gross income for ---------->	Week: $	Month: $		Annual: $

Required:
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)

Patient Name: _____

Visits:

Account #	Date of Service	Account #	Date of Service

Please return this application to:
cashiers@fulhealth.org
Fax: 419-330-2686

OFFICE HOURS:
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Cashier Office
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Wauseon, OH 43567
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