



**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](http://www.fultoncountyhealthcenter.org)

Email: [cashiers@fulhealth.org](mailto: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	15,650	30,120
2	21,150	40,880
3	26,650	51,640
4	32,150	62,400
5	37,650	73,160
6	43,150	83,920
7	48,650	94,680
8	54,150	105,440

FAMILY				
SIZE	HCAP	CHARITY	300% FPL	400% FPL
1	15,960	31,920	47,880	63,840
2	21,640	43,280	64,920	86,560
3	27,320	54,640	81,960	109,280
4	33,000	66,000	99,000	132,000
5	38,680	77,360	116,040	154,720
6	44,360	88,720	133,080	177,440
7	50,040	100,080	150,120	200,160
8	55,720	111,440	167,160	222,880

DOS 1/17/2025 – 1/12/2026

Add \$5,550 for each additional person if the family unit has more than eight members.

DOS 1/13/2026 – Present

Add \$5,680 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 <b>active Medicaid recipient</b> at the time of your hospital service? <i>If Yes, enter Medicaid recipient ID number _____</i>	Yes _____ No _____
---	--------------------

Did you have health insurance (other than Medicaid) at the time of your service? <i>If Yes: Insurance Name: _____ Policy Holder: _____ Policy# _____</i>	Yes _____ No _____
---	--------------------

Were you a resident of Ohio at the time of your hospital service?	Yes _____ No _____
---	--------------------

<b>Date(s) of Hospital Service:</b>	<b>From:</b>	<b>To:</b>
-------------------------------------	--------------	------------

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 <b>3 months</b> prior to date of service:	\$	\$	\$	TOTAL: \$
--	----	----	----	-----------

3. Total family GROSS income for <b>12 months</b> 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:**

Monday - Friday 8:00 am - 4:30 pm

Fulton County Health Center  
Cashier Office  
725 South Shoop Avenue  
Wauseon, OH 43567  
419-330-2669 Option 2