PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY AND APPLICATION

Southern Ohio Medical Center provides free or discounted care for basic, medically necessary services to individuals qualifying for the Financial Assistance Program or Hospital Care Assurance Program (HCAP). Patients must use all other resources, including application to the local Department of Job and Family Services, before financial assistance will be considered. Eligibility for assistance is based upon total gross income (how much you make before taxes) and the number of dependents in the family. Eligible patients will not be charged more for emergency or other medically necessary care than amounts generally billed to those patients who have insurance. To apply, complete the application below. **TO SEE IF YOU QUALIFY FOR FINANCIAL ASSISTANCE OR TO APPLY ONLINE, VISIT SOMC.MYFA.APP.** You may also visit our website at **www.SOMC.org** or call Patient Accounting at 740-356-7638.

	HCAP-Yearly Income	Charity – Yearly Income		
Persons in Family/ Household	100% Discount	100% Discount	75% Discount Range	66% Discount Range
1	Up to $15,060	Up to $30,120	$30,121-$37,650	$37,651-$45,180
2	Up to $20,440	Up to $40,880	$40,881-$51,100	$51,101-$61,320
3	Up to $25,820	Up to $51,640	$51,641-$64,550	$64,551-$77,460
4	Up to $31,200	Up to $62,400	$62,401-$78,000	$78,001-$93,600
5	Up to $36,580	Up to $73,160	$73,161-$91,450	$91,451-$109,740
6	Up to $41,960	Up to $83,920	$83,921-$104,900	$104,901-$125,880

For families/households with more than 6 persons, add $10,760.00 for each additional Person to get the household income that qualifies for free care.

**Discounts Effective 02/01/2024*

FAMILY MEMBERS/TAX DEPENDENTS

Name (Please Include Self)	Date of Birth	Relationship to patient
(Self)		

1. Was the patient a resident of Ohio at the time of service? **Yes**___ **No**____
2. Did the patient have Medical Insurance or was the patient an active Medicaid recipient at the time of service?
   Yes____ **No**____

If you answered **yes** to question 2, please include a copy of your insurance or Medicaid card with this application

If you report $0 income, please provide a brief explanation of how you are surviving financially:

_____

_____

Complete the household income amounts below. If supporting income documentation is needed, it will be requested at a later date.
The 3 and 12 month income requested below must be prior to date(s) of service provided.

Account Number	Patient Name	Date of Service	Household Income for 3 mo prior to hospital service	Household Income for 12 mo prior to hospital service	Recent 6 months income for Household

By my signature below, I certify that everything that I have stated on this application and on my attachments are true.

Applicant's signature

_____

Date

_____

Please mail this form to:
Southern Ohio Medical Center
1248 Kinneys Lane
Portsmouth, Ohio 45662
or Fax: 740-356-7647

Southern Ohio Medical Center

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