*Who Qualifies for the Hospital Care Assurance Program?**

*This program includes charges for services from May 22, 1992, but does not cover physician or take-home pharmacy charges.

- ♦Residents of Ohio
- ♦Residents who are not currently on Medicaid.
- ♦Residents who are part of a family with income at, or below, the federal poverty guidelines, as indicated below:

Federal Poverty Guidelines

Effective January 20, 2012

Family Size	Income/Year
1	$11,170
2	15,130
3	19,090
4	23,050

*For families with more than 4 members, add $3,960 for each additional member.

Effective January 20, 2013

Family Size	Income/Year
1	$11,490
2	15,510
3	19,530
4	23,550

*For families with more than 4 members, add $4,020 for each additional member.

Effective January 20, 2014

Family Size	Income/Year
1	$11,670
2	15,730
3	19,790
4	23,850

*For families with more than 4 members, add $4,060 for each additional member.

How to Apply for Hospital Care Without Charge

1. Read the portion of this brochure, "Who Qualifies For Free Hospital Care?" to see if you qualify.
2. If you believe you may qualify, complete this application.
   Please Note: The entire application MUST be completed and signed. All necessary forms and paperwork must be provided in order to be considered. Incomplete applications will be returned until all requested information is provided.
3. Attach verification of family income for 3 or 12 months prior to service date: wages, unemployment, or Social Security disability checks.
4. Attach copy of Form 1040 for previous year.
5. Turn in your completed application at the admitting Office of Magruder Hospital, or at the Patient Financial Service Office – or, mail to:

Magruder Hospital
615 Fulton Street
Port Clinton, Ohio 43452
419/734-3131

Questions? Call Patient Financial Service Department 419/732-4004

You May Qualify for Free Hospital Care

Magruder Hospital, Port Clinton, Ohio, provides hospital care without charge to qualifying individuals. To qualify, you must submit this application along with all necessary forms and paperwork.

MAGRUDER HOSPITAL
It's How We Care

615 Fulton Street • Port Clinton, OH 43452
www.magruderhospital.com
419-734-3131

Patient Financial Services
419-732-4004

HOSPITAL CARE ASSURANCE/FINANCIAL ASSISTANCE PROGRAMS APPLICATION

Patient Name:_____Phone:_____Date:_____

Address:_____
Street City State Zip Code
Guarantor Name, if different from patient:_____County:_____

Were you an Ohio resident at the time of your hospital service? Yes_____ No_____
Were you an active Medicaid recipient at the time of service? Yes_____ No_____
Were you an active recipient of Disability Assistance at the time of service? Yes_____ No_____
Did you have health insurance at the time of service? Yes_____ No_____

If you answered yes to any of the above questions, please attach a copy of your insurance card, effective during your hospital service, to this application.

Please list below the patient's immediate family who live in the household. A household is defined as parent(s), spouse, and children under the age of 18, natural or adopted, who reside in the address listed above. If the patient is a child and both parents do not reside in the same household, both incomes are still required.

NAME	AGE	RELATIONSHIP TO PATIENT	GROSS INCOME 3 MOS PRIOR	GROSS INCOME 12 MOS PRIOR	TYPE OF INCOME ATTACHED
Total person in family		**total family income**			

Income verification, required by the hospital, must include pay stubs, social security income, pension, or unemployment, income tax return (last filed from the date of service), and/or other documents containing income information for the appropriate time period (3 or 12 months prior to the hospital service). **If you do not qualify for HCA based on the Federal Poverty Income Guidelines on the reverse side of this application, please compete the application as Magruder Hospital has a financial assistance program available based on a sliding scale of the same guidelines. Magruder Hospital reserves the right to contact you for further clarification or documentation regarding income.**

If you report $0 income, please provide a brief explanation of how you (or the patient) are surviving financially.

_____
_____
_____

By my signature below, I certify that everything I have stated on this application and on any attachment is true.

Applicant Signature_____Date_____

OFFICE USE ONLY

Account number_____ total charges $_____
Date of Service _____total write-off $_____
Medical record number_____B/D or A/R _____

MAGRUDER HOSPITAL, 615 FULTON STREET, PORT CLINTON, OHIO 43452

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