How to apply

Complete a separate application for each inpatient admission unless patient is readmitted for the same condition within 45 days of discharge.

Outpatient service eligibility is valid for 90 days from the first date of service.

1. Fill in the **DATE(S) OF SERVICE**.
2. ALL applicable areas on the application form must be **COMPLETED**.
3. The application form must be **SIGNED** and **DATED**.
4. If patient is a minor child:
   - The **NAMES OF BOTH PARENTS** must be provided, whether or not they are living in the home.
   - **INCOME** (if known) **FOR BOTH PARENTS** must be provided, whether or not they are living in the home.
   - **EXAMPLES OF INCOME** include gross wages (before taxes), child support, alimony, rental income, unemployment compensation, social security benefits, public assistance, etc.
5. **GROSS INCOME DOCUMENTATION MUST BE PROVIDED** for the correct period of time indicated on the application form (3 months or 12 months **PRIOR** to the date of service). This does **NOT** include the month of service.

   INCOME DOCUMENTATION may be pay stubs, statement of earnings from employer, or determination of benefits from SSI, SSD. Note: W2's can only be used if the date of service is in January.

   If income is listed on the application, documentation **MUST** be provided for that income. Please provide **COPIES ONLY – DOCUMENTS WILL NOT BE RETURNED**.

   Incomplete income information **WILL NOT** be accepted without an explanation.
6. **IF INCOME IS ZERO ($0.00), YOU MUST** provide a short explanation of how living expenses are being met.
7. **VERIFY, SIGN AND DATE THE APPLICATION.**
8. **SUBMIT application and all documentation:**
   - **ONLINE:** Through your MyChart account
   - **BY MAIL:** Akron Children's Hospital Care Assurance, P.O. Box 910, Akron, OH 44309-0910
   - **BY EMAIL:** Email documents to fincounsel@akronchildrens.org
   - **IN PERSON:** Admitting on the 3rd floor of the hospital or any patient registration site.
   - **BY FAX:** 330-543-3146

Akron Children's Hospital

You may qualify for free or reduced-cost hospital care. Akron Children's offers financial assistance to families who cannot pay their hospital bills.

1. HCAP: To qualify for free care, patients must be Ohio residents, not currently on Medicaid, have family income at or below Federal Poverty Guidelines.

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
1	$14,580
2	$19,720
3	$24,860
4	$30,000
5	$35,140
6	$40,280
7	$45,420
8	$50,560
For families/households with more than 8 persons, add $5,140 for each additional person.	

2. If you are not eligible for HCAP or have income above the poverty level, you may qualify for other assistance. Akron Children's offers reduced cost or charity care to families who have financial hardship. Please visit https://akronchildrens.org/pages/Financial-Assistance.html

Call Financial Counseling for questions on financial assistance and how to apply: 330-543-2455.

Translation services available: Assistance provided in other languages. Contact Language Access Services for help.

One Perkins Square
Akron, OH 44308
330-543-1000
akronchildrens.org
01/23 - 5016

Akron Children's Hospital

Do you need help paying hospital bills?

Akron Children's Hospital may provide free or reduced-cost care.

If you need financial help:

1. The Hospital Care Assurance Program (HCAP) provides free care to families who qualify.
2. Akron Children's offers reduced-cost or charity care for those who are not eligible for HCAP.

If you need help paying your hospital bill:

- Fill out this application. For questions on what help is offered and how to apply, contact Financial Counseling at fincounsel@akronchildrens.org or 330-543-2455.

If you have a question about your bill, call Customer Service: 330-543-8500, 800-933-7440

Akron Children's Hospital

Financial Assistance Application (HCAP/Charity Care)

Date(s) of Service: _____

Akron Children's Hospital offers a Financial Assistance Program to all patients in financial need, at all income levels, based on a sliding scale. Patients who do not qualify for assistance through Medicaid may qualify for charity care based on the Federal Poverty Guidelines.

Patient Information

Full Name _____

Address _____

City _____

State _____ Zip _____

Phone _____

Patient SSN _____

#1 Guarantor (*Person responsible for paying bill*)

Full Name _____

Address _____

City _____

State _____ Zip _____

Phone _____

#2 Guarantor (*Person responsible for paying bill*)

Full Name _____

Address _____

City _____

State _____ Zip _____

Phone _____

The following questions must be answered to process your application:

1. Was patient an Ohio resident on the date of hospital service? ☐ Yes ☐ No
2. Did patient have health insurance other than Medicaid at time of service? ☐ Yes ☐ No If yes, insurance company name and ID number: _____
3. Was patient an active Medicaid recipient at the time of service? ☐ Yes ☐ No If yes, Medicaid recipient ID number: _____

☐ Check if you are self-employed and include your 1040 and appropriate schedule, or W2/1099 Profit/Loss Statement for 3 months prior to date of service.

Provide the following information for the patient and all people who live in the home. For HCAP, "family" is defined as: patient, patient's parents, all patient's siblings (natural or adoptive). *Attach additional sheet if needed.

FAMILY MEMBER'S NAME	RELATIONSHIP TO PATIENT	BIRTHDATE	SOURCE OF INCOME OR EMPLOYER NAME	YEARS ON JOB	GROSS INCOME FOR **3** MONTHS PRIOR TO DATE OF SERVICE	GROSS INCOME FOR **12** MONTHS PRIOR TO DATE OF SERVICE
1.	*Patient*					
2.						
3.						
4.						
5.						
6.						

Income documentation must accompany this application. Examples of income include gross wages (before taxes), child support, alimony, rental income, unemployment compensation, social security benefits, public assistance, etc.

If you reported zero ($0.00) income, please explain below how basic food and housing needs were provided prior to the date of service. *Attach additional sheet if needed.

OFFICE USE ONLY	
HCAP	CHARITY
1.	
2.	
3.	
4.	
5.	
6.	

BY MY SIGNATURE BELOW, I AFFIRM THAT TO THE BEST OF MY KNOWLEDGE THE ANSWERS ON THIS APPLICATION ARE TRUE AND COMPLETE. I AUTHORIZE **AKRON CHILDREN'S HOSPITAL** TO ACT ON MY BEHALF IN QUALIFYING ME FOR THE BEST ASSISTANCE I AM ELIGIBLE FOR. IN ORDER TO PROVIDE SUPPORT, I UNDERSTAND AN **AKRON CHILDREN'S HOSPITAL** REPRESENTATIVE MAY CONTACT ME FOR ADDITIONAL INFORMATION OR USE A THIRD PARTY ORGANIZATION TO VERIFY THE FINANCIAL INFORMATION STATED ON THIS APPLICATION.

_____ _____

Applicant/Parent Signature Date

☐ * Check here if a second sheet is included with this application