

FAIRFIELD MEDICAL CENTER  
Lancaster, Ohio

**NOTICE OF AVAILABILITY FOR UNCOMPENSATED SERVICES**

Fairfield Medical Center is required by law to give a reasonable amount of its service without charge to eligible persons who cannot afford to pay for care.

To be eligible to receive uncompensated care, your family income must be at or below the following levels.

SIZE OF FAMILY	POVERTY GUIDELINES WITHOUT CHARGE	POVERTY GUIDELINE AT REDUCED CHARGE
1	\$ 9,800	\$ 19,600
2	13,200	26,400
3	16,600	33,200
4	20,000	40,000
5	23,400	46,800
6	26,800	53,600
7	30,200	60,400
8	33,600	67,200
<b>For Each Additional Family Member Add:</b>	\$ 3,400	\$ 6,800

**FAIRFIELD MEDICAL CENTER  
SLIDING SCALE CALCULATION 2006**

Family Size	Greater Than	Up To	Greater Than	Up To	Greater Than	Up To
1	9,800	12,250	12,250	14,700	14,700	19,600
2	13,200	16,500	16,500	19,800	19,800	26,400
3	16,600	20,750	20,750	24,900	24,900	33,200
4	20,000	25,000	25,000	30,000	30,000	40,000
5	23,400	29,250	29,250	35,100	35,100	46,800
6	26,800	33,500	33,500	40,200	40,200	53,600
7	30,200	37,750	37,750	45,300	45,300	60,400
8	33,600	42,000	42,000	50,400	50,400	67,200
<b>Patient Share of Usual Charge</b>		25%		50%		75%
<b>Write Off</b>		75%		50%		25%

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FINANCIAL STATEMENT  
REQUEST FOR DETERMINATION OF ELIGIBILITY FOR UNCOMPENSATED SERVICES

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Guarantor Name, if not patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have health insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Were you an active recipient of Disability Assistance at the time of your hospital service? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If you answered yes to either question, please attach a copy of your insurance or DA card tot his application.;

**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 adopted) who live in the patient's home.**

1. Total number of persons in patient's immediate family who live in the household: \_\_\_\_\_

NAME	AGE	RELATIONSHIP TO PATIENT

2. \*Reported gross income must be for time periods prior to the date(s) of hospital service.

Signed and notarized statement of income for the previous 3 months \$ \_\_\_\_\_

Signed and notarized statement of income for the previous 12 months \$ \_\_\_\_\_

**\*INCOME VERIFICATION MUST ACCOMPANY THIS APPLICATION**

3. Please check income verification attached: \_\_\_\_\_ Copies of Pay Stubs \_\_\_\_\_ Other

4. Please check proof of Ohio residence attached: \_\_\_\_\_ Copy of Driver's License \_\_\_\_\_ Voter's Registration Card

\_\_\_\_\_ Copy of Canceled Mail \_\_\_\_\_ Other

5. If you reported \$0 income, please provide a brief explanation of how you (or the patient) are surviving financially. This statement will need to be notarized.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**THIS AREA IS RESERVED FOR NOTARY**