Blanchard Valley HEALTH SYSTEM

Financial Assistance Program

Dear Patient,

Under the Ohio Hospital Care Assurance Program (HCAP), Blanchard Valley Health System offers basic, medically necessary hospital-level services free of charge to individuals who are residents of Ohio whose income is at or below the Federal Poverty Income Guidelines.

In addition to the HCAP program, Blanchard Valley Health System provided financial assistance on a sliding scale to patients who live in surrounding counties in Ohio who meet family income levels up to (250%) times the Federal Poverty Guidelines regardless of insurance status.

2022 Federal Poverty Income Guidelines

Family Size	*HCAP 2022 Federal Poverty Income Level	BVHS Financial Assistance Program (Family income up to 250% of Federal Poverty Level)
1	$13,590	$33,975
2	$18,310	$45,775
3	$23,030	$57,575
4	$27,750	$69,375
5	$32,470	$81,175
6	$37,190	$92,975
7	$41,910	$104,775
8	$46,630	$116,575

*For families/households with more than 8 persons, add $4,720 for each additional person
*Before we consider your application for Financial Assistance, we will determine if you are eligible for a state program.

Completing Application for Financial Assistance

Your application **must** be signed and completed, or your application will be closed.

In order to determine eligibility for HCAP or Financial Assistance, we look at your family income and size, and available assets.

Eligibility for HCAP

1.) You must be a resident of Ohio
2.) You must be at or below 100% of the Federal Poverty Income Guidelines in the 3-month period prior to the date of service.
3.) Family members include you, your spouse and/or natural/adopted children under the age of 18 living at home.

Eligibility for BVHS Financial Assistance

1.) You must be between 101%-250% of the Federal Poverty Guidelines
2.) Family members include you, your spouse and/or natural/adopted children under the age of 18 living at home.

Submit completed applications

Mail:
Blanchard Valley Hospital
Attn: Financial Assistance
1900 S. Main St
Findlay, OH 45840

Email:
creditdepartment@bvhealthsystem.org
(Must be a PDF format)

In person:
1900 S. Main St Findlay, Oh
Findlay Hospital cashiers window

*In order to expedite processing your application, please make sure all information is provided. Missing information will result in a closed application.

Financial Assistance Program
Continued

Name: ____ Account Number: ____________________

Applicant name, if not the patient: ____

Address: ____

Date(s) of service: _____________ to ________________ SSN: _________________________________

1.) Did you have medical insurance at the time of service? Yes____ No____
    If yes, please provide insurance name and ID number ____
2.) Were you a recipient of Medicaid for this date of service? Yes____ No____
3.) Was this service related to an auto accident, work injury, or third-party liability claim? Yes____ No____
    If yes which one ____
4.) Is there any attorney representation or settlement expected? Yes____ No____
5.) Were you residing in Ohio during this date of service? Yes____ No____

*Income verification documents must be submitted with the application. These can include pay stubs, W-2, income tax return, social security award letter, etc. These must be provided for the 3-month period prior to your date of service.
Bank statements do not qualify as verification of income

Name (list patient first)	Date of Birth	Relationship to the patient	Income for 3 months prior to the date of service	Income for 12 months prior to date of service

Total # in family: _____________ Total income: _______________

Employer information: Patient/Guarantor employer for the last 12 months:

Name of employer: ___________________________ Date hired: _______ Date ended: _______

Name of employer: ___________________________ Date hired: _______ Date ended: _______

Spouse's employer for the last 12 months:

Name of employer: ___________________________ Date hired: _______ Date ended: _______

Name of employer: ___________________________ Date hired: _______ Date ended: _______

If you reported no income, please provide a brief explanation as to how you are being supported:

____

By my signature below, I certify that everything I have stated on this application and any attachments is true. I give Blanchard Valley Health System permission to evaluate my financial status and determine eligibility for various financial assistance programs. In addition, I realize that any money received to me by an insurance company or third-party liability aware, due to services performed for the specific dates of service covered by this application could result in my financial assistance being reversed. I accept responsibility for full and immediate payment of any and all outstanding balances.

Patient/Guarantor Signature: ___________________________________ Date________________