# HOSPITAL CARE ASSURANCE PROGRAM (HCAP) / CHARITY CARE / FINANCIAL ASSISTANCE APPLICATION

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|---|---|---|
| **Patient Name**<br>(Last) (First) (MI) | | **Medical Record Number** |
| **Street Address** | | **Account Number** |
| **City and State** | | **Patient's Date of Birth** |
| **Zip Code** | **Phone Number** | **Date(s) of Service** |

**Was the patient an Ohio resident at the time of service?** ❑ Yes ❑ No

**Did the patient have any insurance coverage at the time of service?** ❑ Yes ❑ No

**Was the patient an active Medicaid recipient at the time of service?** ❑ Yes ❑ No

**If yes, enter Medicaid recipient ID number:**

**Was the patient an active recipient of Disability Assistance at the time of service?**
*If yes, please attach a copy of your DA card effective during date(s) of service.* ❑ Yes ❑ No

**Are these services a result of a motor vehicle accident?** ❑ Yes ❑ No

*Please provide the following information for all the people in the patient's immediate family that live in the home. For purposes of HCAP, "family" is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural and adoptive) who reside with the patient. For patient's under the age of eighteen (18), the "family" shall include the patient, the patient's natural or adoptive parent(s), and the parent(s)' children under 18 (natural or adoptive) who reside with the patient.*

| Name of Family Member | Age | Relationship to Patient | Employer or Source of Income Name | Income for 3 Months | Income for 12 Months |
|---|---|---|---|---|---|
| | | Self | | | |
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| **Total Persons in Family:** | | | **Total Family Income:** | | |

**Attach income verification to this application. Income verification may include pay stubs, W-2s, or other documents containing income information for the appropriate time period prior to the date(s) of service (3 or 12 months).**

**If you reported $0.00 income, provide a brief explanation of how the patient was being supported:**

By my signature below, I certify that the above information is true and accurate to the best of my knowledge. Further, I will apply and take any reasonable action needed to get assistance to pay my hospital charges. Financial assistance is a source of last resort. Any other liability or possible payor will be exhausted prior to awarding assistance.

**Applicant Signature** **Date of Application**

**Please return completed application to:**
Patient Financial Counselor
639 W. Main St., Barnesville, OH 43713
Fax: 740-425-5790

**For further assistance:**
please call 740-425-5136
or visit the Patient Financial Counselor
Monday-Friday, 8:00 AM-4:30 PM