

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

Patient Name (Last) (First) (MI)	Patient Account Number
Address	Date of Service
City and State	Patient's Date of Birth
Zip Code Home Phone Number	Patient's Social Security Number

Did you have health insurance covering these services?  Yes  No

Were you an Ohio resident at the time of the hospital service?  Yes  No

Were you an active Medicaid recipient at the time of your hospital service?  Yes  No  
If yes, enter recipient billing #: \_\_\_\_\_

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

Please provide the following information for all of the people in your immediate family, including yourself. For purposes of HCAP, "family" is defined as the patient, the patient's spouse (regardless of whether they live in the patient's home), and all the patient's children under 18 (natural or adoptive) who reside with the patient.

Family Members Name	Age	Relationship to Patient	Source of Income or Employer Name	Hire/Start Date	Income for 3 months	Income for 12 months
(patient)		self				
<b>Totals:</b>						

Attach income verification to this application. Income verification may include pay stubs, income tax returns, W2's or other documents containing income information for the appropriate time period (3 or 12 months prior to hospital service or include 3 or 12 months current income):  
\*If you reported \$0.00 income provide an explanation of how you were being supported:

**VALUE OF ASSETS**

Home:  Own  Rent Monthly payment: \$ \_\_\_\_\_

Checking Account Balance: \$ \_\_\_\_\_ Savings Account Balance: \$ \_\_\_\_\_

Total Investments: \$ \_\_\_\_\_ Investments Description: \_\_\_\_\_

Other Assets Value: \$ \_\_\_\_\_ \$ \_\_\_\_\_

Description of Assets (Car, Boat, Etc.) \_\_\_\_\_

Other Income: \$ \_\_\_\_\_ Other Income Description: \_\_\_\_\_

Monthly Total Expenses (House payment, car payment, utilities, food, etc...): \$ \_\_\_\_\_

Please send the completed application to:

O'Bleness Memorial Hospital  
55 Hospital Drive  
Athens, Ohio 45701  
or fax to: 740-592-9466
For further assistance, you may call 740-592-9439 or visit a financial counselor at an OhioHealth hospital.

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 (Medicaid, Medicare, Insurance, etc.) to pay my hospital charges. Financial assistance is a source of last resort. Any other liability or possible payer will be exhausted prior to awarding assistance.

**I understand that this application (or form) is made so that the hospital can see if I am eligible for HCAP or financial assistance based on the defined criteria. If any information I have given proves to be untrue, I understand that the hospital may re-check my financial status and take whatever action is appropriate.**

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Interviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

