

BARNESVILLE HOSPITAL ASSN.
Application for HCAP (Free Care) or Financial Assistance

PATIENT NAME _____ DATE OF APPLICATION _____

APPLICANT NAME, IF NOT PATIENT _____
 (If the applicant is not the patient, please answer the following questions as they apply to the patient.)

STREET _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____

DATE(S) OF HOSPITAL SERVICE: From _____ To _____

- Were you an Ohio resident at the time of your hospital service? Yes _____ No _____
- Were you an active Medicaid recipient at the time of your hospital service?
 If yes, Medicaid recipient ID number _____ Yes _____ No _____
- Were you an active recipient of Disability Assistance at the time of your hospital service? Yes _____ No _____
 (If you answered Yes to this question, please attach a copy of your DA card effective during your hospital services on this application.)
- Did you have health insurance (other than Medicaid) at the time of your hospital service? Yes _____ No _____

Please provide the following information for all the people in your immediate family who live in your 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 or adoptive) who live in the patient's home. If the patient is under the age of 18, the "family" shall include the patient, patient's natural or adoptive parent (s) and the parents' children under the age of 18 living in the patient's home.

Name of Family Member	Age	Relationship To Patient	Income for 3 Mo. Prior to Hospital Service *	Income for 12 Mo. Prior to Hospital Service *	Type of Income Verification Attached **
Total persons in family		Total family income			

* Income verification should accompany this application. If you reported \$ 0 income, provide a brief explanation on the back of this form or on an attached sheet.
 ** Income verification may include pay stubs, W-2s or other documents containing income information for the three or twelve months prior to the date of service.

By my signature below, I certify that everything I have stated on this application and on any attachments is true.

 Applicant Signature

 Date