BARNESVILLE HOSPITAL

Policy Title: BO - HCAP Policy

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_____

1. Were you an Ohio resident at the time of your hospital service? Yes____ No____

2. Were you an active Medicaid recipient at the time of your hospital service? Yes____ No____
   If yes, Medicaid recipient ID number: _____

3. 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 service to this application.)

4. Did you have health insurance (other than Medicaid) at the time of your hospital service? Yes____ No____

Please provide the following information for all of 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 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 live in the patient's home.

Name of Family Member	Age	Relationship to Patient	Income for 3 months prior to hospital service*	Income for 12 months 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 (3) or twelve (12) 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