

ODJFS Application for HCAP (Free Care)

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: _____

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

- Were you legally married at the time of your hospital service? Yes _____ No _____
- 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? Yes _____ No _____
If yes, Medicaid recipient ID number: _____
- 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.)
- 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 a minor child, the patient's living parents must be counted as "family" regardless of whether they live in the patient's home. Make sure to provide information for your spouse as well as yourself. If your spouse has \$0 income, please make sure to document this. There is room on back to make additional comments.

Name of family member (s)	Age	Relationship to Patient	Gross income for 3 months prior to hospital service*	Gross income for 12 months prior to hospital service*	Type of income verification attached**

Total persons in family		Total family income			
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*Income verification should accompany this application for you and your spouse. ***If you reported \$0 or very low income provide a brief explanation on the back of this form or on an attached sheet. (Explain why income is \$0, and what is your means of survival with \$0 income)***

**Income verification for you and your spouse may include, pay stubs or other documents containing income information for the appropriate time period (3 or 12 months prior to hospital service).

By my signature below, I certify that everything I have stated on this application and on any attachments is true and I have no additional non-reported income.

Applicant signature

Date

IF REPORTING \$0 INCOME WHO PROVIDES THE FOLLOWING:

SHELTER _____

FOOD _____

TRANSPORTATION _____

UTILITIES _____

CLOTHING _____

HOW LONG HAS IT BEEN LIKE THIS: FROM _____ TO _____

ADDITIONAL COMMENTS REGARDING \$0 INCOME:

FREE CARE INFORMATION

If you have Disability Assistance (D.A.) your card will be the document that lets the hospital know that you are eligible for free care. Please provide a copy.

If you are not a D.A. recipient, you may be eligible for free care depending on your income. Proof of income will be necessary for the hospital to determine your eligibility.

In the January 23, 2009 Federal Register, the Department of Health and Human Services released the 2009 poverty income guidelines. They are as follows:

FAMILY SIZE	INCOME GUIDELINES
1	\$10,830
2	\$14,570
3	\$18,310
4	\$22,050
5	\$25,790
6	\$29,530
7	\$33,270
8	\$37,010

Add \$3,740 for each additional person if the family unit has more than eight (8) members.