HCAP and Financial Assistance Program Application



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| Application Date: | Date of Service: | Patient Name: | Guarantor Name: |
| Address, City and State: | | | Phone: |

*Circle One*

1. Was the patient a resident of Ohio at the time of service? Yes No
2. Did the patient have medical insurance at the time of service? Yes No
3. Was the patient an active Medicaid recipient at the time of service? Yes No
4. Were you married at the time of service? Yes No

Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, etc. “Family” is defined as the patient, the patient’s spouse, and all the patient’s children under 18 (natural or adoptive) who live in the home. If the patient is a minor, the “family” is defined as the patient, the patient’s natural or adoptive parents and parent’s children (natural or adoptive) who live in the patient’s home.

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| --- | --- | --- | --- | --- | --- | --- |
| Family Members Name | Age | Date Of Birth | Relationship to Patient | Source of Income or Employer Name | Income 3 months prior to Date of Service | Income 12 months prior to Date of Service |
|  |  |  | Self |  |  |  |
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**Proof of income will be requested with the submission of the application for 3 months prior to the date of service. If you report $0.00 income, please provide a letter with a brief explanation of how you survive financially.**

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*My signature below certifies that everything I have stated on this application is correct and subject to review under the audit. I understand that it is unlawful to knowingly submit false information to obtain government benefits.*

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*Applicant’s Signature Date*

Please return completed application to:

East Liverpool City Hospital

(Attn: Patient Financial Services)

425 West 5th Street, East Liverpool, OH