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

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

Was there health insurance coverage for the services? ☐ Yes ☐ No

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

Was there 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	List Employer or source of Income Name	Hire/Start Date for all income	Income for 3 months	Income for 12 months
(patient)		self				
Totals:						

Attach income verification to this application. Income verification may include pay stubs or other documents containing income information for the appropriate time period (3 or 12 months prior to service or include 3 or 12 months current income):

*If you reported $0.00 income provide an explanation of how you were being supported. *If no longer working, please provide last date worked.

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:

OhioHealth Mansfield and Shelby Hospitals
335 Glessner Avenue
Mansfield, OH 44903-9989
or fax to: 419-520-2565

For further assistance, you may call 419-526-8428 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. I authorize OhioHealth to obtain financial information from other sources such as a credit report or property search and/or information from a collection agency if needed.

OhioHealth

Applicant Signature: _____ Date: _____

Interviewer Signature: _____ Date: _____