Sample Application for HCAP

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_____

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. 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, 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	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*
(Patient)		self			
Total persons in family		**Total family income**			

*Income verification, if required by the hospital, may include pay stubs, w-2s, 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.

_____ _____
Applicant Signature Date