



PATIENT BILLING HCAP APPLICATION

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: _____ EMPLOYER: _____

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.

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 must accompany application. If you reported \$0 income, provide a brief explanation on an attached sheet.*

***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's Signature

Date