

**Application for Uncompensated Care (HCAP)**

1. 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.)

2. Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

3. Phone: \_\_\_\_\_ Date(s) of Hospital Service: From \_\_\_\_\_ To \_\_\_\_\_

4. Fill in the following information if it applies

- Were services related to an Auto Accident? \_\_\_\_\_  
 If yes, Please fill in your Auto Insurance Information.  
 Auto Insurance Company: \_\_\_\_\_  
 Auto Insurance Address: \_\_\_\_\_  
 Attorney Name \_\_\_\_\_ Phone #: \_\_\_\_\_

- 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 \_\_\_\_\_

**5-6.** Please provide the following information for all 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**

\*Income verification may be requested by financial counselor.

\*\*Income verification 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.

7. Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**DEPARTMENT OF HEALTH AND HUMAN SERVICES POVERTY GUIDELINES**

Family Size	2009 Income	2008 Income	2007 Income	2006 Income	2005 Income	2004 Income
1	10,830.00	10,400.00	10,210.00	9,800.00	9,570.00	9,310.00
2	14,570.00	14,000.00	13,690.00	13,200.00	12,830.00	12,490.00
3	18,310.00	17,600.00	17,170.00	16,600.00	16,090.00	15,670.00
4	22,050.00	21,200.00	20,650.00	20,000.00	19,350.00	18,850.00
5	25,790.00	24,800.00	24,130.00	23,400.00	22,610.00	22,030.00
6	29,530.00	28,400.00	27,610.00	26,800.00	25,870.00	25,210.00
7	33,270.00	32,000.00	31,090.00	30,200.00	29,130.00	28,390.00
8	37,010.00	35,600.00	34,570.00	33,600.00	32,390.00	31,570.00