Henry County Hospital, Inc. Rev 01/21/26
1600 East Riverview Avenue
Napoleon, Ohio 43545

Application for HCAP (Hospital Care Assurance Program)
Incomplete applications will be returned

1. Patient Name:_____ **Date of Application**:_____
Applicant Name, If not Patient:_____ **Date of Birth:**_____
(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_____ **(If applicable)**

4. Episode number; (s) _____

5. Fill in the following information if it applies:

- 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: _____
- 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	Gross Income for 3 months prior to hospital service*	Gross Income for 12 months prior to hospital service	Type of income verification

7. Additional Documentation Required:

a. Please document your gross income for 3 or 12 months prior to your date of service in Sections 5-6 of the completed application.
b. If you had -0- income prior to date of service, please provide an explanation below of how you are surviving:

_____
_____
_____

By my signature below, I certify that everything I have stated on this application and on any attachments is true.
I affirm that the information provided on this application is true and accurate, and I understand that it is unlawful to knowingly submit false information to obtain government benefits.

Applicant Signature_____ **Date**_____

1. DEPARTMENT OF HEALTH& HUMAN SERVICES POVERTY GUIDELINES					2. HENRY COUNTY HOSPITAL FINANCIAL ASSISTANCE				
Family Size	**2026 Income**	**2025 Income**	**2024 Income**	**2023 Income**	**Family Size**	**2026 Income**	**2025 Income**	**2024 Income**	**2023 Income**
1	15,960	15,650	15,060	14,580	**1**	31,920	31,300	30,120	29,160
2	21,640	21,150	20,440	19,720	**2**	43,280	42,300	40,880	39,440
3	27,320	26,650	25,820	24,860	**3**	54,640	53,300	51,640	49,720
4	33,000	32,150	31,200	30,000	**4**	66,000	64,300	62,400	60,000
5	38,680	37,650	36,580	35,140	**5**	77,360	75,300	73,160	70,280
6	44,360	43,150	41,960	40,280	**6**	88,720	86,300	83,920	80,560
7	50,040	48,650	47,340	45,420	**7**	100,080	97,300	94,680	90,840
8	55,720	54,150	52,720	50,560	**8**	111,440	108,300	105,440	101,120