Henry County Hospital, Inc. Rev 01/19//23

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(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:**

1. Please provide gross income for 3 or 12 months prior to your date of service with completed application. Income verification may include pay stubs and/or other documents containing income information for the appropriate time period.
2. If you had -0- income prior to date of service, please provide and 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.**

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

|  |  |
| --- | --- |
| 1. **DEPARTMENT OF HEALTH& HUMAN SERVICES POVERTY GUIDELINES**
 | 1. **HENRY COUNTY HOSPITAL FINANCIAL ASSISTANCE**
 |
| **Family Size** | **2023****Income** | **2022****Income** | **2021****Income** | **2020****Income** | **Family Size** | **2023****Income** | **2022****Income** | **2021 Income** | **2020****Income** |
| **1** | 14,580 | 13,590 | 12,880 | 12,760 | **1** | 29,160 | 27,180 | 25,760 | 25,520 |
| **2** | 19,720 | 18,310 | 17,420 | 17,240 | **2** | 39,440 | 36,620 | 34,840 | 34,480 |
| **3** | 24,860 | 23,030 | 21,960 | 21,720 | **3** | 49,720 | 46,060 | 43,920 | 43,440 |
| **4** | 30,000 | 27,750 | 26,500 | 26,200 | **4** | 60,000 | 55,500 | 53,000 | 52,400 |
| **5** | 35,140 | 32,470 | 31,040 | 30,680 | **5** | 70,280 | 64,940 | 62,080 | 61,360 |
| **6** | 40,280 | 37,190 | 35,580 | 35,160 | **6** | 80,560 | 74,380 | 71,160 | 70,320 |
| **7** | 45,420 | 41,910 | 40,120 | 39,640 | **7** | 90,840 | 83,820 | 80,240 | 79,280 |
| **8** | 50,560 | 46,630 | 44,600 | 44,120 | **8** | 101,120 | 93,260 | 89,200 | 88,240 |