950 W Wooster Street
Bowling Green, OH 43402

Application for HCAP/Financial Assistance

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 Address: ______________________________**City:**__________________________**State:**________**Zip:**______________

DATE OF HOSPITAL SERVICE:_______________________**to**______________________________

1. Were you an Ohio resident at the time of your hospital service? Yes____ No____
2. Were you in Ohio solely for the purpose of medical care? Yes____ No____
3. Were you an active Medicaid recipient at the time of service? Yes____ No____
   If yes, provide Medicaid billing ID number_____________________________
4. Were you an active recipient of Disability Assistance at the time of service? Yes____ No____
5. Did you have health insurance at the time of your hospital service? Yes____ No____

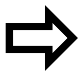
Please provide the following information for all the people in your immediate family who live in your home. For purposes of HCAP, "family" is defined as the patient, the patient's spouse, and all of the patient's children under the age of 18 (natural or adoptive) who live in the patient's home.

Name:	**Age**	**Relationship to patient**	**Income for 3 months prior to hospital service***	**Type of income verification**
Patient:		Self		
Total persons in family:				

*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 of (3) months prior to hospital service.

***If reporting zero income, please give a brief explanation below as to how you (the patient) are surviving:**

By my signature below, I certify that everything I have stated on this application and on any attachments is true.

 **Applicant Signature**_______________________________________ **Date:**________________