



APPLICATION FOR HOSPITAL CARE ASSURANCE PROGRAM (HCAP)

PATIENT NAME: _____ DATE: _____

APPLICANT NAME, IF NOT PATIENT: _____
(If applicant is not the patient, answer the following questions as they apply to the patient)

STREET _____ CITY: _____

STATE: _____ ZIP CODE: _____

	From	To	ACCT#	\$ DOLLAR AMT	
Date(s) of Service:	_____	_____	_____	_____	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> ER
	_____	_____	_____	_____	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> ER
	_____	_____	_____	_____	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> ER

Did you have health insurance at the time of your hospital service? Yes ___ No ___

Were you an active recipient of Disability Assistance 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 Ohio resident at the time of your hospital service? Yes ___ No ___

If you answered Yes to any question, please attach a copy of your Insurance, Medicaid or DA card to this application. Please provide the following information for all of the people in your immediate family who live in your home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Name	Age	Relationship to Patient	Income 3 months prior to hospital service *	Income 12 months prior to service *	Type of Income Verification attached **
(Patient)		(self)			

Total persons in family _____ Total Family Income _____

*Income verification must accompany this application. If you reported \$0 income you must attach a brief explanation of how you are living financially _____

**Income verification must be attached and may include: PAY STUBS, W-2'S OR OTHER DOCUMENTS CONTAINING INCOME INFORMATION FOR THE APPROPRIATE TIME PERIOD (3 OR 12 MONTHS PRIOR TO HOSPITAL SERVICE).

Mail to: Firelands Regional Medical Center, 1111 Hayes Avenue, Sandusky, OH 44870. Attn: Financial Counseling.

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

Applicant Name _____ Date _____

Hospital Use Only

Approved _____ Denied _____ Reason _____

Financial Counselor _____ Date _____ Reviewed By _____