Memorial HOSPITAL

Hospital Care Assurance Program

If you wish to be considered for financial assistance programs, complete the entire form below and return it to Memorial Hospital. **You are not eligible for Financial Assistance if you are entering the State of Ohio solely to seek medical treatment.**

Patient's Name: _____ Date of Application: _____

Applicant Name (if not the patient): _____ Phone Number: _____

Address: _____

Patient ID Number: _____ Date of Hospital Service: _____

1) Was the patient a resident of Ohio at the time of service? ☒ Yes ☐ No

2) Did the patient have Medical Insurance at the time of service? ☐ Yes ☐ No

3) Was the patient an active Medicaid recipient at the time of service? ☒ Yes ☐ No

If yes, Medicaid recipient ID number: _____

Please provide the following information for all of 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 (regardless of whether they live in the home), and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of eighteen, 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	Date of Birth	Relationship to Patient	Total Income received within the three (3) months PRIOR to date of service	Total Income received within the twelve (12) months PRIOR to the date of service	Source of Income (Job, Pension, Social Security, Unemployment, etc.)
Total Persons in the Family:			**Total Family Income:**		

Income verification is required by the hospital for Hospital Charity Care for an amount over $5,000. Please check the type of income verification attached: Income verification must include the 3 or 12 months prior to the service date. (please send copies – originals will not be returned)

- ☐ Copies of Pay Stubs
- ☐ Letter from employer stating gross income
- ☐ Unemployment benefit verification
- ☐ Verification of **any** income received
- ☐ Social Security / Pension / Disability benefit letter

If you report a **$0 income**, please attach a brief explanation of how you survived financially for the 3 and 12 months prior to the date of service.

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

Applicant Signature: _____ Date: _____

Return this form with income verification to: Memorial Hospital / Patient Financial Services Department / 500 London Ave
Marysville, OH 43040
Phone #: 937.578.2564
Fax #: 937.578.2323
E-mail: financialassistance@memorialohio.com

Office Use Only:

Application Status: ☐ IP ☐ OP ☐ HCAP ☐ Charity Care_____% ☐ Denied Over Income

PFS Rep. Initials: _____ Date: _____ Approval Period: _____