HARRISON COMMUNITY HOSPITAL

951 East Market Street, Cadiz, Ohio 43907

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR UNCOMPENSATED SERVICES

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:_____ CITY:_____

STATE:_____ ZIP CODE:_____

DATE(S) OF HOSPITAL SERVICE: From_____ To_____

1. Were you an Ohio resident at the time of your hospital service? Yes _____ No _____

2. Were you an active Medicaid recipient at the time of your hospital service? Yes _____ No _____

   If yes, Medicaid recipient ID number: _____

3. Were you an active recipient of Disability Assistance at the time of your hospital service? Yes _____ No _____
   (If you answered Yes to this question, please attach a copy of your DA card effective during your hospital service to this application.)

4. Did you have health insurance (other than Medicaid) at the time of your hospital service? Yes _____ No _____

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, 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	Age	Relationship to Patient	Income for 3 months prior to hospital service*	Income for 12 months prior to hospital 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, provide a brief explanation on the bottom of this form or on an attached sheet.

**Income verification may include income tax returns, pay stubs, W-2s, or other documents containing income information for the appropriate time period (3 or 12 months prior to hospital service).

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

_____ _____

Applicant Signature Date

Harrison Community Hospital
951 East Market Street - Cadiz, Ohio 43907

HOSPITAL CARE ASSURANCE PROGRAM

BASIC, MEDICALLY NECESSARY HOSPITAL-LEVEL SERVICES

(In accordance with Ohio Administrative Code under
Medicaid Policy Handbook, Area 5101:3-2-0717)

If your income is under the Federal Poverty Guidelines listed below, please complete this form.

2015 POVERTY INCOME GUIDELINES

FAMILY SIZE	INCOME GUIDELINE
1	$ 11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8	40,890

Add $4,160 for each additional person if the family unit has more than eight members.

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****Office Use Only****

Patient Account Number_____
Date of Service_____

Revised Guidelines for:
Ohio Hospital Care
Assurance Program
Beginning Jan. 22, 2015

HCPR12/0115

PHONE: 740-942-4631 - FAX: 740-942-2749
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