Salem Regional Medical Center
Application for Free Care
Under, Ohio Hospital Care Assurance Program (**HCAP**)

[Section 1]

Patient Name: (print) _____ Date of Application: ___ /___ / ___

Street: _____

City: _____ State: _____ Zip Code: _____

Applicant Name, if not the Patient: _____ (relationship to patient) _____

[Section 2]

Date (s) of Hospital Services: **from** _____ **to**_____

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

2 Were you an active Medicaid recipient at the time of this service? Yes _____ No _____
(If yes, Medicaid billing ID#: _____)

3. Did you have Health insurance other than Medicaid at time of this service? Yes _____ No _____

_____

[Section 3]

Please complete the **FINANCIAL SECTION** below and include information for **you** and your immediate family. For the purpose of this HCAP application, your family includes only the **patient** (you), the patient's **spouse** and all the patient's natural or adopted **children under the age of 18** who live in the patient's home.

Name	Age	Relation to Patient (i.e...spouse,son, daughter)	**Gross** Income total for the month prior to hospital service*	**Gross** Income totaling three (3) months prior to hospital service*	Total of **Gross** Income for year (12 months) prior to hospital service*
(patient)		self			
Total persons in family		**Total family income**:			

*The Hospital reserves the right to review documentation of income. (such as: paystubs, W-2s, self employed taxes, unemployment and workers comp income, cash receipts, pensions, VA, SS, SSI and Disability statements, etc...)

[Section 4]

If no income in the last 3 months, please attach an explanation of how you are surviving financially with zero income and include the date you stopped receiving an income. **See back>**

[Section 5]

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

_____ _____

(**Applicant Signature**) (Date signed)

HOW TO COMPLETE THE APPLICATION ON THE OTHER SIDE

Send completed application to Salem Regional Medical Center, Attention HCAP: 1995 E State St. Salem, Ohio. 44460

Section 1:

- Patient is the person who had the medical service at Salem Regional Medical Center
- Applicant Name, if not Patient would be a parent, guardian, spouse or POA.
- The information on this application should reflect your income and family size as it was on the date(time frame) that medical service was provided to you.

Section 2:

- You must live in Ohio to qualify for HCAP
- List your Medicaid billing number from your Medicaid card
- Provide any insurance information you had at the time of this medical service

Section 3:

- Income for each listed family member must be stated. Include ALL income [coming into] the household, **such as**; Wages, Social Security Income and Pensions. Unemployment income, workers comp benefits, VA benefit, Disability and SSI payments, child support, alimony, and rental income, investment interest, **etc**... are all considered income. The income reported must be from the months BEFORE the hospital service not from the date that you are completing this application. Only dependents **under** 18 can be included on the application as child.

Section 4:

FINANCIAL

- If no income is claimed for this date of service, an explanation needs to be written that explains how long you have been **without an income** and how you are able to survive with zero income for your household. Sign your name under the statement of explanation. Write explanation below or attach letter.

Date of last income: _____

How do you (patient) survive since loss of income? _____

_____

_____

_____

Section 5:

- Must be signed by patient unless patient is unable due to age/physical circumstances. The POA, Guardian or Parent can then sign and write their relationship to the patient.

Questions: Please call 330-332-7393 for questions regarding HCAP or financial assistance