



- Bucyrus Community Hospital       Community Health Associates  
 Galion Community Hospital       GCH Health Services

Application Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print the name of immediate family members\* who have received services at Avita Health System for which assistance is requested.

\_\_\_\_\_

\_\_\_\_\_

\*HCAP definition of "family": 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 18 years of age, the family includes the patient, the patient's natural or adoptive parent(s), and the parent(s)' children under 18 (natural or adoptive) who live in same home as the patient.

Applicant name if applicant was not a patient: \_\_\_\_\_

Dates of service for all patients in the family: From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Family's Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

- Was the patient(s) an Ohio resident at the time of his/her hospital service? Yes\_\_\_\_ No\_\_\_\_  
If no, explain: \_\_\_\_\_
- Was the patient(s) an active Medicaid recipient at the time of his/her hospital service? Yes\_\_\_\_ No\_\_\_\_  
If yes, Medicaid recipient ID number(s): \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_
- Was the patient(s) an active recipient of Disability Assistance at the time of his/her hospital service? Yes \_\_\_\_ No\_\_\_\_  
(If yes, attach a copy of patient's DA card)
- Did the patient have health insurance (other than Medicaid) at the time of his/her hospital service?  
Yes\_\_\_\_ No\_\_\_\_ If yes, provide name of insurance \_\_\_\_\_

Provide the following information for all immediate family\* members who live in your home. (See above for definition of "family")

Name	Birth Date	Family Relationship (father, mother, child of ____)	Employer	Income for the 3 months before hospital service	Income for the 12 months before hospital service	Type of income verification attached**
				\$	\$	
				\$	\$	
				\$	\$	
				\$	\$	
				\$	\$	
# of family members			Total family income	\$	\$	

**\*\*INCOME VERIFICATION IS REQUIRED TO PROCESS YOUR APPLICATION**

- Wages, self-employment, child support/alimony: Most recent tax return and/or W-2, copy of pay stubs, copy of court documents
- Social security: Award letter, copy of bank statement showing monthly deposit amount
- Pension, dividends, interest, rental income: Benefits letter, check copies or bank statement with electronic deposits, dividend/interest statement
- Unemployment, workers' compensation: Benefit letter

If you report \$0 income, provide a brief explanation on the back of this form on how you are meeting basic living needs, including who provides shelter, food, transportation, utilities, clothing and how long you have been supported by this person(s) and/or agency(ies).

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

Applicant Signature \_\_\_\_\_

Date \_\_\_\_\_