PATIENT BILLING
HCAP APPLICATION

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:_____

Galion Community Hospital

PHONE: _____ EMPLOYER: _____

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.

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 application. It you reported $0 income, provide a brief explanation on an attached sheet.*
***Income verification, if required by the hospital, may include 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.

SM/2-09

_____ _____
Applicant's Signature Date