Mary Rutan Hospital
HCAP/Charity Assistance Application

Office Use Only:

All questions/blocks on the application are required to be considered for any financial assistance.
Please write legibly in blue or black ink only.
PATIENT NAME: _____

APPLICANT NAME, IF NOT PATIENT: _____
(If the applicant is not the patient, please answer the following questions as they apply to the patient)

Date of Birth: _____ Date of Hospital Service: From: _____ To: _____
Street Address: _____ City: _____
State: _____ Zip: _____ Phone Number: _____
Marital Status on Date of Service (Please Circle): Single Married Separated Divorced Widowed

1. Was the patient an Ohio Resident at the time of service? Yes _____ No _____
2. Was the patient an active **Medicaid** recipient at the time of service? Yes _____ No _____
(If YES, Please provide Medicaid ID Number) _____
3. Did the patient have health insurance (**besides Medicaid**) at the time of service? Yes _____ No _____

Please provide the following information for all of the people in the patient's immediate family who live in the home. For the purpose of HCAP, "Immediate Family" is defined as patient's spouse (regardless of living in the home or not), patient's children (younger than 18: biological/adoptive) and both parents (if patient is a minor-regardless of living in the home or not). If the patient is a minor and receives child support, the child support income needs to be totaled and listed as the patient 3 & 12 month income.

Family **GROSS** Current monthly income (before taxes and any deductions):

Name of each "Immidiate Family" member (use back side for additional family members)	Family Members Age	Family members relationship to the patient	Total **GROSS** Income for 3 months PRIOR to date of service	Total **GROSS** Income for 12 months PRIOR to date of service	Source of Income (Name of Employer, Pension, Social Security,Unemployment, ect)
		Self			
Total persons in family:		Total family income 3 & 12 months:			

*If the patient reported $0.00 income, a brief statement of how the patient met their expenses for current, 3 and/or 12 months prior to the date of service. (Can be stated on back of application)

*A statement of support is needed from supporting party along with their signature and date, if patient reported $0.00 income. (Can be stated on back of application)

*A new application is required for every inpatient hospital admission. For outpatient hospital services, a new application is required every 90 days. For Urgent Care or Mary Rutan Clinic services, a new application is required for each date of service.

By signing below, I certify the above and any attached information is correct and complete to be best of my knowledge.
I understand that falsification of any information provided may cause rejection of my HCAP/Charity assistance application.

_____ _____
Patient/Applicant Signature Date

If applicant is not the patient, relationship to patient and the reason the patient is unable to sign for themselves is required.