

**HCAP and Financial Assistance Program Application**

Application Date:	Date of Service:
Patient Name:	Guarantor Name:
Address, City and State:	Phone Number:

- |   |                  |   |
|---|------------------|---|
| 1) Was the patient a resident of Ohio at the time of service?                           | Yes_____ No_____ |   |
| 2) Did the patient have medical insurance at the time of service?                       | Yes_____ No_____ | If you answered <b>yes</b> to questions 2, 3, or 4 please <b>attach a copy</b> of your insurance Medicaid, or DA card to this application |
| 3) Was the patient an active Medicaid recipient at the time of service?                 | Yes_____ No_____ |   |
| 4) Was the patient an active recipient of Disability Assistance at the time of service? | Yes_____ No_____ |   |

**Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, etc.**  
**“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 a minor, the "family" is defined as the patient, the patient's natural or adoptive parents and the parents children (natural or adoptive) who live in the patient's home**

Family Member's Name	Age	Date of Birth	Relationship to Patient	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service
			Self			

**\*\*If you reported \$0 income, please provide a brief explanation below of how you (or the patient) are surviving financially:**

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I affirm that the answers on this application are true, and I understand that it is unlawful to knowingly submit false information to obtain government benefits.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**Return this form with any attachments to:**

**Knox Community Hospital  
 Attn: Patient Financial Services  
 1330 Coshocton Road  
 Mount Vernon, OH 43050  
 740-393-9630**

