WOOSTER COMMUNITY HOSPITAL
CARE ASSURANCE PROGRAM APPLICATION

NOTE: A SEPARATE APPLICATION IS REQUIRED FOR EACH PATIENT AND EACH MONTH OF SERVICE.

Patient Name:	Date of Birth:	Social Security Number:
Address:	Patient Account#:	
State: Zip code:	Date of Service:	

I believe I am eligible for free medical care based on the guidelines of the HCAP Program and would like to begin the application process. Please answer the questions below.

1. Were you an Ohio resident at the time of your service?	YES		NO	
2. Were you eligible for Medicaid at the time of service?	YES		NO	
3. Is your total gross family income at or below the poverty guidelines?	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 age 18 (natural or adoptive) who live in the patient's home.
****If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s) (even if the parent does not live in the child's home), and the parent's other children under 18 (natural or adoptive) who live in the patient's home.**

Name	Age	Relationship to Patient	Total Gross Income For 3 months prior to hospital service*	Total Gross Income for 12 months prior to hospital service*
		SELF		
Total persons in family		Total gross family income		

***If income is $0 please include an explanation of how you are surviving.**

I certify that I have completed the application for hospital care assurance data. I hereby declare under penalty of perjury (28 USC Section 1746) that the foregoing information is true and correct. I understand that further information may be requested of me.

Signature:		Date:	

Available Assistance

Under Ohio law you may be eligible to receive basic, medically necessary hospital services without charge if you are an Ohio resident on Disability Assistance (DA) or your income is at or below the current federal poverty guidelines shown below.

Family Size	Yearly Gross Income Guideline	3 Month Income Guideline
1	$12,490	$3,123
2	$16,910	$4,228
3	$21,330	$5,333
4	$25,750	$6,438
5	$30,170	$7,543
6	$34,590	$8,648
7	$39,010	$9,753
8	$43,430	$10,858

For families with more than eight members, add $4,420 for each additional member. *A family shall include the patient, (or parents of minor patient) their spouse, and all their children, natural or adoptive under the age of 18 who live in the home.

For Hospital Use Only:

_____ A. Eligible for Program
_____ B. Not eligible for Program
_____ Patient contacted on _____/_____/_____ requesting additional data.
____ Patient contacted on _____/_____/_____advising them of denial and their obligation to pay.
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