HCAP APPLICATION FORM
Incomplete applications will not be processed.

Account Number: _____

☐ Aultman Hospital
☐ Aultman Alliance Community Hospital
☐ Aultman Orrville Hospital
☐ Physician Office

_____ _____/_____/_____
Patient Name Date of birth

_____
SSN (optional)

_____
Applicant Name (if not a patient)

If the applicant is not the patient, please answer the following questions as they apply to the patient.

_____
Address

_____ _____
City, State, ZIP Code Phone Number

The following questions must be answered in order to process your application:

1. Were you an Ohio resident at the time of your hospital service? ◯ YES ◯ NO
2. Did you have health insurance other than Medicaid at the time of your service? ◯ YES ◯ NO
3. Were you an active Medicaid/DMA recipient at the time of your service? ◯ YES ◯ NO
   If yes, Medicaid recipient ID number:

_____

4. I authorize **Aultman Health Foundation** to act on my behalf in qualifying me for the best assistance I am eligible for. In order to support you, an Aultman Health Foundation representative may contact you for additional information or use a third-party organization to verify the Medicaid application, to receive notification of meeting and documents that are needed to complete the Medicaid process. ◯ YES ◯ NO
5. ☐ Single ☐ Married ☐ Separated
   (if separated, spouse's income is still required.)
6. Are you Amish? ◯ YES ◯ NO
7. Do you have assets such as 401k, CDs, investments, checking or savings account? ◯ YES ◯ NO

   ☐ Check if you are self-employed and include your 1040 and appropriate schedule.

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State of Ohio HCAP Approved: ◯ **YES** ◯ **NO**

HCAP Eligibility Dates:

from:_____ **to:**_____

Aultman FAP Approved: ◯ **YES** ◯ **NO**

Aultman Physician FAP Approved: ◯ **YES** ◯ **NO**

FAP Discount:_____**%**

Expires: _____

Family members include you, your spouse, and/or natural or adopted children under the age of 18 living in the home. For patients under the age of 18, list the patient, the patient's natural or adoptive parent(s), regardless of whether the parent lives in the home with the patient or not, and the patient's siblings (natural or adoptive) who live in the home.

Name (First, Last)	**Age**	**Relationship to Patient**	**Regular Wages, Pensions, Social Security, SSI, VA Benefits**	**How Often** **Weekly/Every 2 weeks/Monthly**	**Type of Income**	**Total Gross* Income for 3 Months Prior to Service Date** ***Prior to Deductions**	**Total Gross* Income for 12 Months Prior to Service Date** ***Prior to Deductions**	**Please list 401k, CDs or Investments**
Ex. Jane Doe	43	Self	$200.00	Weekly	Unemployment	$2,400.00	$9,600.00	
(Patient)								
Total Family Size:					Total Income:			

NOTE: If you or any family members have no income, you must state "0".

If you reported zero ("0") income, please explain below how basic food and housing needs were provided prior to the date of service:

By my signature below, I affirm that to the best of my knowledge the answers on this application are true. I authorize Aultman Health Foundation to act on my behalf in qualifying me for the best assistance I am eligible for. In order to support you, an Aultman Health Foundation representative may contact you for additional information or use a third party organization to verify the financial information stated in this application.

Applicant Signature **Date**

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Outreach Representative

Signature Date

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