The MetroHealth Financial Assistance Program / HCAP Application

Patient Name: _____ Date of Application: _____
Applicants Name, If Not Patient: _____
(If the applicant is not the patient, please answer the following questions as they apply to the patient)
Address:_____ City:_____
State:_____ Zip Code:_____

DATE(S) OF SERVICE: From _____ To _____

1. Were you an Ohio resident at time of service? Yes_____ No_____
2. Were you an active Medicaid recipient at the time of service Yes_____ No_____
3. Did you have health insurance (other than Medicaid) at the time of service? Yes _____ No_____

Please provide the following information for all 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 of adoptive) who live in the patient's home. If the patient is under the age of eighteen, the Family shall include the patients, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home

| | | | | **Monthly Rates** |
|---|---|---|---|---|
| **Name** | **Age** | **Medical Record#** | **Relationship to Patient** | **Monthly income (includes SSI, alimony, unemployment) Include the benefit type: SSI, BWC, Etc** |
| (Patient) | | | self | |
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*You are required to notify MetroHealth Systems of any changes to household income or health insurance status as a participant in this program.
*I hereby authorize credit and employment information to be released to the MetroHealth System and it's representatives to determine eligibility for benefits. I give my permission to The MetroHealth System to provide my name, address, telephone number and necessary medical and billing information to the organization that assists patients of MetroHealth to qualify for government and other medical benefit programs for purposes of the Hospital Access Patient Assistance Program
*I understand that if I withhold information or present fraudulent information, MetroHealth reserves the right to revoke discounts assigned and retro-adjudicate previously discounted claims.

**By my signature below, I certify that everything I have stated on this application and on any attachments is true**

_____ _____
Applicant Signature Financial Counselor Signature
Date_____ Plan Assigned _____