

PATIENT NAME & SOCIAL SECURITY NUMBER	AGE	# IN FAMILY	MARITAL STATUS	SPOUSE/PARENT/OTHER	PHONE
PATIENT ADDRESS	CITY, STATE, ZIP		PATIENT EMPLOYER		HOW LONG?
GUARANTOR & SOCIAL SECURITY NO.	GUARANTOR ADDRESS		GUARANTOR EMPLOYER		HOW LONG?

WERE YOU AN ACTIVE MEDICAID RECIPIENT AT THE TIME OF YOUR HOSPITAL SERVICE?  
 YES \_\_\_\_\_ NO \_\_\_\_\_

CHECKING \_\_\_\_\_ BALANCE \_\_\_\_\_ OTHER ASSETS \_\_\_\_\_

SAVINGS \_\_\_\_\_ BALANCE \_\_\_\_\_ BANK \_\_\_\_\_

WERE YOU AN OHIO RESIDENT AT THE TIME OF YOUR HOSPITAL SERVICE?  
 Y \_\_\_\_\_ N \_\_\_\_\_

DID YOU HAVE HEALTH INSURANCE(OTHER THAN MEDICAID) AT THE TIME OF YOUR HOSPITAL SERVICE Y \_\_\_\_\_ N \_\_\_\_\_

RENT \_\_\_\_\_ BUYING \_\_\_\_\_  
 OWN \_\_\_\_\_ C/O RELATIVES \_\_\_\_\_

MORTGAGE BALANCE /PROPERTY VALUE \_\_\_\_\_

FAMILY MEMBERS				
NAME	AGE	DOB	RELATIONSHIP/SSN	INCOME

**GROSS INCOME**  
*(Please include copies of income either 3 or 12 months prior to date(s) of service.)*

PATIENT	UNEMP	WORKERS COMP
SPOUSE	PENSION	OTHER
SOC. SECURITY	CHILD SUPPORT	

**BASIC MONTHLY EXPENSES**  
*(in the event that you would not qualify for HCAP and would like to be considered for internal charity, Please include copies of your monthly expenses.)*

HOUSING	WATER	CHILD CARE
GAS	ELECTRIC	
CABLE	PHONE	

**DATES OF HOSPITAL SERVICE**

ACCOUNT NUMBER \_\_\_\_\_ DATE OF SERVICE FROM \_\_\_\_\_ TO \_\_\_\_\_ BALANCE \_\_\_\_\_

ACCOUNT NUMBER \_\_\_\_\_ DATE OF SERVICE FROM \_\_\_\_\_ TO \_\_\_\_\_ BALANCE \_\_\_\_\_

ACCOUNT NUMBER \_\_\_\_\_ DATE OF SERVICE FROM \_\_\_\_\_ TO \_\_\_\_\_ BALANCE \_\_\_\_\_

ACCOUNT NUMBER \_\_\_\_\_ DATE OF SERVICE FROM \_\_\_\_\_ TO \_\_\_\_\_ BALANCE \_\_\_\_\_

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNED \_\_\_\_\_ OR \_\_\_\_\_

SIGNATURE OF PERSON COMPLETING FORM      RELATIONSHIP      DATE

**OFFICE USE ONLY**

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_ Approved for \_\_\_\_\_

DIRECTOR/MANAGER, PATIENT ACCOUNT SERVICES

