Please return application to:
Attn: Financial Counselor
C/O Knox Community Hospital
1330 Coshocton Ave
Mount Vernon, Ohio 43050

Knox Community HOSPITAL

www.KCH.org

FINANCIAL ASSISTANCE / HCAP APPLICATION

For hospital based services and the following provider types: OSU Pathology, Knox Emergency Services, Riverside Radiology, Inpatient Hospitalists, Physicians employed by KCH.

Patient Name: _____ Date of application:_____

Guarantor:_____ Date of Birth:_____

Street:_____ City, State:_____

Zip:_____County:_____ Phone: _____

- Where you a resident of Ohio at the time of service? Y _____N_____
- Did the patient have Medical insurance at the time of service? Y _____N _____
- Was the patient an active Medicaid Recipient at the time of service? Y _____N_____
- Was the patient an active recipient of Disability Assistance at the time of service? Y _____N _____

Please provide the following information for all of the members of your family. "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 parent's children (natural or adoptive) who live in the patient's home.

Family Member's Name	DOB	Relationship to Patient	Source of Income or Employer Name	Income for 3 months prior to date of application and/or date of service

Please include 3 months paystubs for each family member or full tax return for self-employed and current bank statement

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

_____

_____

*Family income means- gross family income, including, but not limited to, wages, salaries, retirement income, disability income, social security, rental or investment income and child support, consistent with the definition of income for determination of income under the State of Ohio Hospital Care Assurance Program (HCAP).

Please list all other assets below (Include bank statements)

_____

_____

*Assets- Family's other assets such as bank accounts, non-primary residential property income, must be utilized to pay bills up to 50% of total assets on hand prior to date of application being eligible for KCH's Financial Assistance or HCAP. Cash or bank accounts of less than $3000.00 will not be considered toward payment of hospital bills.

By my signature below, I certify that everything I have stated on this application is true and correct.

Signature:_____ Date:_____

_____

ELIGIBILITY DETERMINATION (For hospital use only)

The application is approved for **HCAP** *or* **Hospital Charity** at _____% Determination is valid for outpatient services through:_____
Each inpatient admission requires a new application.
The applicant is denied: Reason_____Date:_____
Applicant notified on:_____ Approved by:_____