MEMORIAL HEALTH SYSTEM

HCAP/FINANCIAL ASSISTANCE APPLICATION

Patient Name (Last) (First) (MI)	Patient Account or Statement Number
Address	Date of Service
City, State	*Patient's Date of Birth*
Zip Code *Home Phone Number*	*Patient's Social Security Number*

Did you have health insurance covering these services? ☐ Yes ☐ No

Were you an Ohio resident at the time of the hospital service? ☐ Yes ☐ No

Were you an active Medicaid recipient at the time of your hospital service? ☐ Yes ☐ No
If yes, enter recipient billing # _____

Are these services a result of a motor vehicle accident? ☐ Yes ☐ No

Please provide the following information for all of the people in your immediate family, including yourself. For purposes of HCAP, "family" is defined as the patient, the patient's spouse (regardless of whether they live in the patient's home), and all the patient's children under 18 (natural or adoptive) who reside with the patient.

Family Members Name	Age	Relationship to Patient	Source of Income or Employer Name	Hire/Start Date	Gross Income 3 Months	Gross Income 12 Months
(patient)		Self				
Totals:						

Attach income verification to this application. Income verification may include pay stubs or other documentation containing income information for the appropriate time period (3 or 12 months prior to hospital service). Value of assets must be completed.

***If you reported $0.00 income, provide an explanation of how you were being supported:**

Value of Assets:

Home: ☐ Own ☐ Rent Monthly payment: $ _____

Checking Account Balance: $ _____

Savings Account Balance: $ _____

Certificate of Deposits (CD): $ _____

Bonds/Stocks: $ _____

Monthly Total Expenses (House payment, car payment, utilities, food, etc...): $ _____

Please send the completed application with income verification to:

Marietta Memorial Hospital
401 Matthew Street
Marietta, OH 45750
Email: financialassistance@mhsystem.org

For further assistance, you may call (740) 568-5263 or visit a financial counselor at Marietta Memorial Hospital, Belpre, or MMH Strecker Centers

The financial assistance policy and application are also available at mhsystem.org

REVISED: 10/1/2020

PFA USE ONLY: Family Size _____ HCAP or UCC % _____ HCAP/OS or UCC/OS % _____ _____-_____ IP/OP or OP

I understand that this application (or form) is made so that the hospital can see if I am eligible for HCAP or financial assistance based on the defined criteria. If any information I have given proves to be untrue, I understand that the hospital may re-check my financial status and take whatever action is appropriate.

Please complete all sections of this application (including signature) and include income verification, checking and savings, information for the 3 months prior to the date of service you are applying for. Incomplete applications without income verification, checking and savings documentation will be returned to the applicant and denied until returned complete.

Applicant Signature: _____ **Date** _____