Place label here

Hocking Valley Community Hospital
HCAP and HBCC Application

PO BOX 966
LOGAN OHIO 43138

Date of Application: _______________ Date(s) of Service: _____________________________

Patient Name: _______________________________ Date of Birth: ______________________

Spouse Name: ______________________________

Patient Address: ____

Please provide the following information for all people in your IMMEDIATE FAMILY who reside in your household. For HCAP and HBCC adjustments, FAMILY is defined as patients spouse and children under the age of 18(natural) that reside in your home. IF the patient is under 18, the family shall include the patient, natural mother, natural father and siblings under the age of 18.

TOTAL # OF PERSON'S IN PATIENT'S IMMEDIATE FAMILY: _________

NAME	AGE	RELATION TO PATIENT	ADOPTIVE OR NATURAL	INCOME 3 MONTHS PRIOR TO VISIT	INCOME 12 MONTHS PRIOR TO VISIT
		SELF			

If you reported no income, please provide a brief explanation of how you are living with zero income (If more room is needed, please use back of application)**:**

____.

Were you an Ohio resident at time of service? Yes or No
Did you have health insurance (other than Medicaid) at time of service Yes or No
Were you an active recipient of Medicaid at time of service? Yes or No
Were you an active recipient of disability assistance at time of service? Yes or No

Proof of income may be requested. (Acceptable verification include pay stubs and award letters and W-2's)

I understand that the information in which I provided is subject to verification by HVCH. I also understand that the information I have provided may be made available for review to Federal and State agencies. Under penalty of law, I affirm the above information is true and accurate.

X___________________________________ (Signature of patient, parent, POA or guardian) Date: __________