For office use only
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Dates of Service used:
_____

Hocking Valley Community Hospital
HCAP and HBCC Application

PO BOX 966
LOGAN OHIO 43138
Financial Assistance Questions Call 740-380-8090

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
Patient		SELF			

*****Income verification is required!!*****

Income Verification includes:

- **2 paystubs that are prior to your date of service *and/or***
- **Your SSI/SSDI award letters and Pension statements**

*****All Applications must have this documentation *AND* contain a current bank statement to be considered.**

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

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:_____

2023 HCAP/ Charity Care Income Guidelines

These programs are for patients with or without insurance. Please fill out the attached application. We would love to help you.

HCAP Family Size	Income
1	$14,580
2	$19,720
3	$24,860
4	$30,000
5	$35,140
6	$40,280
7	$45,420
8	$50,560

For the Charity Care Sliding Fee Scale, You can make UP TO the below guideline and receive a discount.

Family Size:	Max Income	Max for Hocking County Residents
1	$51,030	$58,320
2	$69,020	$78,880
3	$87,010	$99,440
4	$105,000	$120,000
5	$122,990	$140,560
6	$140,980	$161,120
7	$158,970	$181,680
8	$176,960	$202,240

PLEASE PROVIDE PROOF OF INCOME WHEN SUBMITTING APPLICATION.