

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER

HOSPITAL CARE ASSURANCE & CHARITY CARE APPLICATION

Patient Name: _____ Patient's S S #: _____ Month of Service: _____
 Address: _____ Patient's DOB: _____ Responsible Party: _____
 City: _____ Patient's Phone #: _____ Relation to Patient: _____
 State: _____ Zip Code: _____

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

Do you have health insurance covering this service? _____ Yes _____ No

Name of Insurance Co.: _____ Policy#: _____ Group #: _____

Do you have Medicaid benefits covering this service? _____ Yes _____ No If yes, enter billing #: _____

Do you have Disability Assistance (DA) benefits? _____ Yes _____ No If yes, enter billing #: _____

Please list all family members (including yourself). Family members include parents, spouses & children (natural or adoptive) under the age of 18 living in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, workers compensation, social security/disability benefits, child support, alimony, pension benefits, etc.

| Family Members | Age | Relationship to Patient | Source of Income or Employer Name | Income Grossed in 3-months prior to date of service |
|---------------------------------|-----|-------------------------|-----------------------------------|---|
| 1. | | <i>Self</i> | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| Total Persons in Family: | xxx | xxxxxxxxxxx | xxxxx Total Income: | |

**** If you report \$0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested above.**

I understand that the information, which I have provided on this application, is subject to verification by Southeastern Ohio Regional Medical Center. I also understand that the information, which I have provided, may be made available for review by federal and/or state enforcement agencies and others. Under penalty of law, I affirm that the information provided is true and correct.

Responsible Party's Signature: _____ Date: _____

By my signature below, I affirm to the best of my knowledge and belief that the answers on the application are true. I further understand and agree that other parties may rely on the information I provide herein. I hereby authorize them to do so.

Hospital Representative's Signature: _____ Date: _____

For Hospital Use Only

| Service: I/P or O/P | Account # | Date of Service | Total Charges | Write Off Amount | Balance Due |
|---------------------|-----------|-----------------|---------------|------------------|-------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Household income one year prior to date of service? _____

Household income three months prior to month of service? _____ X 4 = _____

HCAP: _____ SEORMC Charity: _____ 75%: _____ 50%: _____ 25%: _____ Denied: _____