SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER

HOSPITAL CARE ASSURANCE & CHARITY CARE APPLICATION

Patient Name: _____ Patient's SS #: _____ Date 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	Gross Income 3 mo. prior to date of service	Gross Income 12 mo. prior to date of service
1.		***Self***			
2.					
3.					
4.					
5.					
6.					
Total Persons in Family:	***xxx***	***xxxxxxxxxx***	***xxxxx Total Income:***		

**** If you report $0.00 income above, please provide a brief explanation of how you (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:* _____

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: _____ 80%: _____ 60%: _____ 52%: _____ Denied: _____

You can access Southeastern Med's financial assistance application, Billing, Collections, HCAP and Charity policies on our website at http://www.seormc.org