Financial Assistance/ Hospital Care Assurance Program (HCAP)

For hospital based services and the following provider types: Knox Emergency Services, Riverside Radiology, inpatient Hospitalists, and physicians employed by KCH.

Patient Name: _____

Date of Application: _____/_____/_____

Guarantor Name: _____

Date of Service: _____/_____/_____

Street Address: _____

City/State: _____/_____

County: _____

Phone: (_____) _____-_____

Please answer the following questions:

☐Y ☐N 1. Were you a resident of Ohio at the time of service?

☐Y ☐N 2. Did the patient have medical insurance at the time of service?

☐Y ☐N 3. Was the patient an active Medicaid recipient at the time of service?

☐Y ☐N 4. Was the patient an active recipient of Disability Assistance at the time of service?

Please provide the following information for all of the members of your family. "Family" is defined as the patient, the patient's spouse and all of the patient's children under 18(natural or adoptive) who live in the patient's home. If the patient is a minor, the "family" is defined as the patient, the patient's natural or adoptive parents and the parent's children (natural or adoptive) who live in the patient's home.

Family Member's Name	DOB	Relationship to Patient	Source of Income or Employer Name	Income for 3 months prior to date of service (OFFICE USE ONLY)

Please include pay stubs - 3 months prior to date of service for each family member or full tax return for self-employed and **bank statements: month of date of service and 2 months prior, checking and savings**, if you reported $0 income, please provide a brief explanation below of how you (or the patient) are surviving financially:

_____

_____

*FAMILY INCOME MEANS- *gross family income, including, but not limited to, wages, salaries, retirement income, disability income, social security, rental or investment income and child support, consistent with the definition of income for determination of income under the State of Ohio Hospital Care Assurance Program (HCAP).*

For Financial Counselor Use:

_____

_____

*ASSETS- *Family's other assets such as bank accounts, non-primary residential property income; PROPENSITY TO PAY, MAJOR CREDIT CARDS must be utilized to pay bills up to 50% of total assets on hand prior to date of application being eligible for KCH's Financial Assistance / HCAP. Cash or bank accounts of less than $3000.00 will not be considered toward payment of hospital bills.*

By my signature below, I certify that everything I have stated on this application is true and correct.

_____ _____/_____/_____

APPLICANT'S SIGNATURE DATE

Return this form with any attachments to:

Knox Community Hospital
C/O Financial Counselors
1330 Coshocton Avenue, Mount Vernon, OH 43050

ELIGIBILITY DETERMINATION (For hospital use only) $_____ ASSETS TO BE UTILIZED TOWARDS ACCOUNT BEFORE ASSISTANCE BEGINS

The application is approved for HCAP or hospital charity at _____%. Determination is valid for outpatient services through:_____. Each inpatient admission requires a new application.

The applicant is denied. (REASON) | Date:_____/_____/_____ _____

Applicant notified on:_____/_____/_____ Approved by:_____

On January 1, 2014,
the Affordable Care Act became law.

What Does This Mean FOR YOU?

As of January 1, 2014, when you, the patient, present to a Physician Office and/or Knox Community Hospital for a visit and/or procedure, you will be asked for your insurance information at the time of initial registration. If you indicate that you do not currently have medical insurance, you will be directed to visit www.healthcare.gov, the health insurance marketplace created under the Affordable Care Act.

The Affordable Care Act requires that all Americans apply for health insurance coverage or be subject to a financial penalty. If you choose to pay the penalty rather than apply for health coverage, neither Knox Community Hospital nor it's medical providers can consider you eligible for financial assistance.

When you visit the health insurance marketplace at **www.healthcare.gov**, *you will have the opportunity to apply for a health insurance option that is right for you. It is important to ensure that Knox Community Hospital is a provider for the network plan you select.*

In some cases, it may be determined that you, the patient, are eligible for Medicaid Coverage, at which time the site will direct you to **benefits.ohio.gov**, *where you can apply for that assistance.*

Once you, the patient, have obtained the appropriate health coverage for which you are eligible, you may apply for financial assistance through KCH's Financial Assistance program to cover any coinsurance amounts and other qualifying expenses.

Knox Community HOSPITAL

www.KCH.org

If you have any questions or need assistance with your health coverage, please contact one of KCH's Certified Application Specialists, who can help you fulfill these new requirements under the Affordable Care Act, and ensure that you remain eligible for any financial assistance for which you may qualify.

To contact one of Knox Community Hospital's Certified Application Specialists, please call a Financial Counselor at 740.393.9631, 740.393.9639, 740.399.3831, 740.326.3378, or 740.326.3368.

Knox Community HOSPITAL

www.KCH.org

Financial Assistance Information for Knox County residents