

## Paulding County Hospital

### HOSPITAL CARE ASSURANCE APPLICATION

Patient Name: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_ Account Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ Date of Service(s): \_\_\_\_\_ Family Member Interviewed: \_\_\_\_\_  
 City: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_ Responsible Party: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Patient's Phone #: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

During your admit date were you a resident of the State of Ohio? Yes  No

Era usted residente del estado de Ohio?

Did you have health insurance in at your admit date covering these services? Yes  No  If yes, enter information below & attach copy of insurance card

Tenia usted seguro medico para cubrir estos servicios?

Si contesto si entre la informacion abajo y incluya copia de la tarjeta del seguro.

Name of Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Nombre de la Compañia de Seguro Medico. No. de poliza No. de grupo

Did you have Medicaid benefits at your admit date Yes  No  If yes, enter billing # \_\_\_\_\_ & attach copy of Medicaid card

Tenia usted beneficios de Medicaid?

Si responde si, anote el # de tarjeta

e incluya una copia de la tarjeta de Medicaid

Did you have Disability Assistance (DA) benefits at your admit date? Yes  No  If yes, enter billing # \_\_\_\_\_ & attach copy of DA card

Tenia usted beneficios del Programa de Asistencia por Inpedimentos (DA)?

Si responde si, anote el # de tarjeta

e incluya una copia de la tarjeta de DA

Please list all "family" members (including yourself). Family members include parents, spouses (regardless of whether they live in the home) & children (natural or adoptive) under the age of eighteen (18) living in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, social security benefits, public assistance, etc. Liste por favor a todos los miembros de la familia (inclusive usted mismo). Los miembros de la familia incluyen a padres, los esposos (a pesar de si ellos viven en el hogar) & niños (natural o adoptivo) bajo la edad de dieciocho (18) viviendo en el hogar *junto con el paciente*. Los ingresos incluyen *grueso (antes de impuestos) los sueldos, los ingresos de la renta, compensacion de desempleado, los beneficios de seguro social, asistencia publica, etc.*

Family Members Miembros de Familia	Age as of Edad	Relationship to Patient Relación con el paciente	Source of Income or Employer Name Fuente de Ingreso o Nombre del Empleador	Income from 3 months prior to the date of service Ingreso de tres meses antes de la fecha de servicio	Income from 12 months prior to the date of service Ingreso de doce meses antes de la fecha de servicio
1.					
2.					
3.					
4.					
5.					
6.					
TOTALS					

NOTE: If any of the family members had no income during the above time periods, please mark "NONE" as the income source and place 0.00 as the income  
 NOTA: Si cualquiera de los miembros de la familia no tuvo ingresos durante los periodos de tiempo mencionados, marque por favor "NINGUNO" como la fuente de ingresos y coloque 0.00 como los ingresos

If you reported \$0.00 or no income above, please provide a brief explanation below of how you (or the patient) survived financially during the above time period. Si usted informó \$0.00 o ningun ingreso arriba, por favor proporcione una explicación breve de cómo usted (o el paciente) sobrevivió financieramente durante el periodo de tiempo mencionado.

I affirm that the answers on this application are true, and I understand that it is unlawful to knowingly submit false information to obtain government benefits.  
 Afirmo que las respuestas en esta aplicación son verdad, y yo entiendo que es ilegal someter conscientemente información falsa para obtener los beneficios del gobierno

Applicant Signature: \_\_\_\_\_  
 Firma de la persona responsable

Date Completed: \_\_\_\_\_  
 Fecha Actual

A new or updated application is required for each month in which services are provided.

## STATE FISCAL YEAR 2020 FINANCIAL ASSISTANCE GUIDELINES

Persons in Family Unit	100% Assistance "HCAP"	90% Assistance	80% Assistance	70% Assistance	60% Assistance	50% Assistance	40% Assistance	30% Assistance	20% Assistance	10% Assistance
1	\$12,760	\$14,036	\$15,312	\$16,588	\$17,864	\$19,140	\$20,416	\$21,692	\$22,968	\$24,244
2	\$17,240	\$18,964	\$20,688	\$22,412	\$24,136	\$25,860	\$27,584	\$29,308	\$31,032	\$32,756
3	\$21,720	\$23,892	\$26,064	\$28,236	\$30,408	\$32,580	\$34,752	\$36,924	\$39,096	\$41,268
4	\$26,200	\$28,820	\$31,440	\$34,060	\$36,680	\$39,300	\$41,920	\$44,540	\$47,160	\$49,780
5	\$30,680	\$33,748	\$36,816	\$39,884	\$42,952	\$46,020	\$49,088	\$52,156	\$55,224	\$58,292
6	\$35,160	\$38,676	\$42,192	\$45,708	\$49,224	\$52,740	\$56,256	\$59,772	\$63,288	\$66,804
7	\$39,640	\$43,604	\$47,568	\$51,532	\$55,496	\$59,460	\$63,424	\$67,388	\$71,352	\$75,316
8	\$44,120	\$48,532	\$52,944	\$57,356	\$61,768	\$66,180	\$70,592	\$75,004	\$79,416	\$83,828
For each additional person add	\$4,480	\$4,928	\$5,376	\$5,824	\$6,272	\$6,720	\$7,168	\$7,616	\$8,064	\$8,512