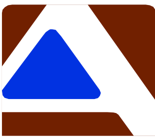

Aultman Hospital
Hospital Care Assurance Program

Account Number ____________________
(if known)

PATIENT NAME: ______________________________________ Patient Date of Birth: ____/_____/______
APPLICANT NAME, IF NOT PATIENT:
(If the applicant is not the patient, please answer the following questions as they apply to the patient.)

STREET: ____

CITY: __________________ STATE: ________ ZIP CODE: _______________

Phone Number: ______________________________ Social Security Number (optional) _________-______-_________

1. Were you an Ohio resident at the time of your hospital service? Yes____ No____

2. Were you an active Medicaid recipient at the time of your hospital service? Yes____ No____

   If yes, Medicaid recipient ID number: ____________________

3. Did you have health insurance (other than Medicaid) at the time of your hospital service? Yes____ No____

* Please list all "family" members. Family members include parents, spouses (regardless of whether they live in the home) & children (natural or adoptive) under the age of eighteen living in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, social security benefits, pension income, etc.

Name	Age	Relationship to Patient	Gross Income for 3 months prior to hospital service*	Gross Income for 12 months prior to hospital service*	Employer and years on job
(Patient)		self			
Total persons in family		**Total family income**			

If you reported $0.00 income above, please provide a brief explanation of how you (or the patient) are surviving financially:

____

By my signature below, I affirm that to the best of my knowledge the answers on this application are true, and that it is unlawful to knowingly submit false information to obtain government benefits. In order to support you, Aultman Health Foundation may use third party organizations to verify the financial information stated on this application.

______________________________ ______________________________
Applicant Signature Date

Office Use Only Eligibility Dates: From _______________ To_______________

Signed: ____ Date: ___________________
Outreach Representative