Western Reserve Hospital
1900 23rd Street, Cuyahoga Falls, OH 44223
(330) 255-3101

Application for Financial Assistance
• Ohio Hospital Care Assurance Program (HCAP) • WRH Patient Financial Assistance Program

Please Print All Information

PATIENT'S NAME (LAST, FIRST, M)	SOCIAL SECURITY NO.	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP CODE

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED*	Employment status at time of service ☐ Employed ☐ Retired ☐ Unemployed	1. WERE YOU AN OHIO RESIDENT AT THE TIME OF YOUR HOSPITAL SERVICE**?** ☐ YES ☐ NO
DATE OF SERVICE	HOSPITAL ACCOUNT NO.	2. WERE YOU AN ACTIVE MEDICAID RECIPIENT AT THE TIME OF YOUR HOSPITAL SERVICE? ☐ YES ☐ NO *IF YES, MEDICAID BILLING NUMBER:*_____ 3. WERE YOU AN ACTIVE RECIPIENT OF DISABILITY ASSISTANCE AT THE TIME OF YOUR HOSPITAL SERVICE ☐ YES ☐ NO

APPLICATION COVERS AN INPATIENT STAY AND/OR THREE MONTHS (MONTH OF SERVICE AND THE TWO FOLLOWING MONTHS)	INSURANCE ☐ YES ☐ NO

SPOUSES NAME (LAST, FIRST, M)	Employment status at time of service ☐ Employed ☐ Retired ☐ Unemployed	SOCIAL SECURITY NO.	DATE OF BIRTH

"Family" includes the patient, patient's spouse ***(regardless of whether they live in the home)** and all patient's children, natural or adoptive, **under the age of 18 who live in the home**. If patient is under the age of 18, the "family" shall include patient, patient's natural or adoptive parent(s) ***(regardless of whether they live in the home)** and the parents children under the age of 18 who live in the home.

FAMILY MEMBERS NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	GROSS INCOME EARNED WITHIN THE THREE MONTHS BEFORE MONTH OF SERVICE	SOURCE OF INCOME OR EMPLOYER NAME
(Patient)		self		
(Spouse)				
TOTAL PERSONS IN FAMILY		**TOTAL FAMILY INCOME**		

$0 INCOME STATEMENT:

_____

Provide brief statement of how basic food/housing needs were met in the three months before your service.

*Income of a spouse or parent who does not live in the home is required unless the absent spouse or parent does not contribute to the household; use INCOME block to document "Does not contribute".

**Income verification includes, but is not limited to copies of total wages before taxes, pension, SSI/SSD/Unemployment benefits, alimony, child support (if child is patient), veterans' benefits, distributions from a retirement account (IRA), 401(k), and 401(b).

If you receive Social Security or Disability Benefits, a letter of income verification or your most recent 1099 form may be submitted. A letter of verification can be obtained by calling the Social Security Administration at 1-800-772-1213.

I, the undersigned, have provided the above information to be considered for financial assistance through Western Reserve Hospital and;

To the best of my knowledge, I state this to be true and accurate information, and;

I understand that these are Federal funds and accept the responsibility of their use on my behalf, and;

I understand that Western Reserve Hospital reserves the right to modify or cancel this program in accordance with the rules of the Ohio Department of Jobs and Family Services (ODJFS).

X_____ _____
(PATIENT OR A LEGAL REPRESENTATIVE OF A PATIENT MUST SIGN FOR APPLICATION TO BE VALID) (DATE)

X_____ _____
(HOSPITAL REPRESENTATIVE SIGNATURE/DEPT. OR AGENCY) (DATE)

WESTERN RESERVE HOSPITAL
Proudly Physician Owned

A NOTICE TO OUR PATIENTS

Dear Patient,

The Federally funded Ohio Hospital Care Assurance Program and Western Reserve Hospital Financial Assistance Programs apply to hospital charges only. **These programs do not include any Physician services or professional billing fees.**

Western Reserve Hospital will provide basic, medically necessary hospital care, *free of charge to qualifying individuals. To be considered eligible, you must:

- **Be a resident of Ohio**
- **Not be currently enrolled in Medicaid**
- **Be an individual or from a family whose income is at or below the Federal Poverty Income Guideline listed below:**

FAMILY SIZE	2016 Care Assurance Income Guidelines	2017 Care Assurance Income Guidelines
1	$11,880	$12,060
2	$16,020	$16,240
3	$20,160	$20,420
4	$24,300	$24,600
5	$28,440	$28,780
6	$32,580	$32,960
7	$36,730	$37,140
8	$40,890	$41,320
Each additional	Add $4,160	Add $4,180
Three-Year Application Deadline - The free care requirement was first imposed on May 22, 1992. Note that only patients served after December 14, 2000 are bound by the three-year application deadline. Hospitals must still accept application at any time from a patient served before December 14, 2000.		

Western Reserve Hospital Financial Assistance Program - This program is not funded and is exclusive to Western Reserve Hospital. Western Reserve Hospital's administration approved this program to provide basic, medically necessary care free of charge to individuals from families whose house hold income is marginally above the Federal guideline to up to 400% the Federal guideline. (Program is subject to cancellation or change at any time)

To apply, please complete and sign the application on the reverse side. In order for us to process your application in a timely manner, you must provide the required information. Mail your completed application to the address below. Written notification of approval or denial will be mailed to you. If you have future services, you will be required to submit a new application.

For additional information please call Customer Service at 330-255-3101

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Attn: Patient Financial Services
1900 23rd Street
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