dayton children's

For hospital use only: ☐ Approved or ☐ Denied

Coverage Span: _____

MRN: _____

Dayton Children's HCAP and Financial Assistance Application

Patient Name: _____ **Patient Date of Birth:** _____

Name of person completing application: _____

*(if the applicant is not the patient, please answer the following questions as they apply to the patient. Any answers to these questions will not impact eligibility for Financial Assistance or delay a patient's ability to receive care ** Questions for HCAP eligibility only.)*

Address: _____ City: _____ State: _____ Zip: _____

Phone number: _____

** Were you an Ohio resident at the time of your hospital service? Yes: _____ No: _____

** Were you an active Medicaid recipient at the time of your hospital service? Yes: _____ No: _____

If yes, provide your Medicaid ID number: _____

** Have you applied for Medicaid benefits within the last 90 days? Yes: _____ No: _____

** Were you an active recipient of disability assistance at the time of your hospital stay? Yes: _____ No: _____

(*if yes, attach a copy of your DA card.)*

** Did you have health insurance (other than Medicaid) at the time of your hospital service? Yes: _____ No: _____

Please list all family members (including yourself). Family members include parents, spouse and children (natural or adoptive) under the age of eighteen (18) living in the home along with the parent.

Family Member	Age	Relationship to parent	Income for 3 months prior to date of service	Income for 12 months prior to date of service
total persons in family		**total family income prior to hospital service**		

If you reported $0 income, please provide a brief explanation below or on an attached sheet.

_____

_____

Document verification must be provided:

☐ Employment = 3- or 12-month income or signed self-attestation if paid in cash
☐ Self-Employment = 1040 tax return including schedule C & signed self-attestation of income
☐ Benefit Letter = Social Security, Unemployment, VA, Pension or Disability
☐ Other = Other income such as rental income, etc.

By my signature below, I certify that everything I have stated on this application and on any attachments is true to the best of my knowledge and belief. I understand a Dayton Children's representative may contact me for additional information to verify the financial information stated on this application.

Patient/applicant signature: _____ Date: _____

Please return to:

Dayton Children's Hospital
One Children's Plaza
Dayton, Ohio 45404
Questions? Call - 937-641-5727
Fax – 937-641-6101
FinancialAdvocates@childrensdayton.org