

HOSPITAL CARE ASSURANCE APPLICATION / UNINSURED CHARITY ASSISTANCE PROGRAM APPLICATION

UH Case Medical Center
 UH Bedford Medical Center
 UH Geauga Medical Center
 UH Geneva Medical Center
 UH Conneaut Medical Center
 UH Richmond Medical Center
 UH Ahuja Medical Center

Patient Name: _____ Medical Record Number: _____ Account #: _____
 Address: _____ Month of Service: _____ Account #: _____
 City: _____ Patient's Date of Birth: _____ Account #: _____
 State: _____ Zip Code: _____ Patient's Social Security #: _____ Account #: _____

Are you a resident of the State of Ohio? Yes No
 Do you have health insurance covering these services? Yes No *If yes, enter information below & attach copy of insurance card*
 Name of Insurance Company: _____ Policy #: _____ Group #: _____
 Are you eligible for COBRA? Yes No
 Do you have Medicaid benefits? Yes No *If yes, enter billing # _____ & attach copy of Medicaid card*
 Do you have Disability Assistance (DA) benefits? Yes No *If yes, enter billing # _____ & attach copy of DA card*

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.

Family Members	Age	Relationship to Patient	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service
1.					
2.					
3.					
4.					
5.					
6.					
7.					
TOTALS					

If you reported \$0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested above.

By my signature below, I affirm to the best of my knowledge and belief that the answers on this application are true. I understand that it is unlawful to knowingly submit false information to obtain government benefits. I further understand and agree that other parties may rely on the information I provide herein. I hereby authorize them to do so.

Responsible Party Signature: X _____ **Date Completed:** _____
 Hospital Representative Signature: _____ Date Completed: _____

Eligibility: HCAP Uninsured _____ **FOR OFFICE USE ONLY**

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

How to Apply

1. Read the back of this form to learn who qualifies.
2. If you believe you may qualify, complete this application.

PLEASE NOTE:

The entire application must be completed and signed to be considered.

3. Include copies of income verifications such as pay stubs, social security determinations, workers compensation checks, tax returns, etc.

Questions?

**Call us at 216-844-8299 or
1-800-859-5906 9 a.m.-4 p.m.**

4. Mail your completed application to:

**University Hospitals
MSC Building
ATTN: Customer Service
3605 Warrensville Ctr Rd
Shaker Heights, OH 44122**

Under State law, this hospital must provide, without charge, certain Basic Medically Necessary Hospital Services to individuals who meet all the following requirements:

1. Individuals must be residents of the State of Ohio
2. Individuals cannot be enrolled in the Medicaid Program
3. Personal or family income is at or below the Federal Poverty Line

“Basic Medically Necessary Hospitals Services” include all inpatient and outpatient services covered under the Medicaid Program, except organ transplants and assoc. services. They do not include physician services.

Federal Income Guidelines*

Family Size	Yearly Income
1	\$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890

For each additional family member add \$3,960 yearly.

*Guidelines are subject to change.

We encourage our patients to apply for all third party benefits, including Medicaid. Thank you.



**YOU MAY QUALIFY FOR
FREE HOSPITAL CARE**

**University Hospitals provides
hospital charity/financial
assistance to qualifying
individuals.**

**TO QUALIFY, YOU MUST
SUBMIT THIS APPLICATION**