Coshocton Regional Medical Center

HCAP and Financial Assistance Program Application

Application Date:	Date of Service:
Patient Name:	Guarantor Name:
Address, City, and State:	Phone Number:

1) Was the patient a resident of Ohio at the time of service? Yes____ No____
2) Did the patient have medical insurance at the time of service? Yes____ No____
3) Was the patient an active Medicaid recipient at the time of service? Yes____ No____

Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, etc. "Family" is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is a minor, the "family" is defined as the patient, the patient's natural or adoptive parents and the parents children (natural or adoptive) who live in the patient's home.

Family Member's Name	Age	Date of Birth	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
			Self			

Proof of income will be requested with the submission of the application.
If you report $0.00 income, please provide a letter with a brief explanation of how you survive financially.

My signature below certifies that everything I have stated on this application is correct and subject to review under audit.
I understand that it is unlawful to knowingly submit false information to obtain government benefits.

Applicant's Signature _____ Date _____

Please return completed application to:

Coshocton Regional Medical Center
Attn: Patient Financial Services
Po Box 428
1460 Orange Street
Coshocton, OH 43812

Revised 07/01/2021