MEMORIAL HEALTH SYSTEM

HCAP/FINANCIAL ASSISTANCE APPLICATION

for Marietta, Belpre, Selby and Sistersville locations

For further assistance, you may call (740) 568-5263 or visit a financial counselor at Marietta Memorial Hospital, Belpre Oncology Center, Wayne St., or Selby.

The financial assistance policy and application are also available at mhsystem.org

Applicant Name ____
Last *First* *MI*

Street Address ____

City ______________ State ________ Zip __________ Phone ____________

Date(s) of Service ____________________

Account Number(s) ____________________

1. Are these services a result of a motor vehicle accident ◯ Yes ◯ No
2. Was the patient(s) an Ohio resident at the time of his/her service? ◯ Yes ◯ No
3. Was the patient(s) an active Medicaid recipient at the time of his/her service? ◯ Yes ◯ No
   If yes, Medicaid recipient ID number(s): ____________________
4. Did the patient(s) have health insurance (other than Medicaid) at the time of his/her service?*If yes, provide name of insurance:* ____________________ ◯ Yes ◯ No

Please provide the following information for all of the people in your immediate family, including yourself. For purposes of HCAP, "family" is defined as the patient, the patient's spouse (regardless of whether they live in the patient's home), and all the patient's children under 18 (natural or adoptive) who reside with the patient

Family Members Name *Definition of Family above	**Birth Date**	**Relationship to Applicant**	**Total Gross Income**		
			Source of Income *(e.g. Employment, SSI, Child Support, Alimony)*	**3 months before the oldest date of service**	**12 months before the oldest date of service**
Patient		**SELF**			
Totals:					

If you report $0 or minimal income, provide a brief explanation below on how you are meeting basic living needs, including who provides shelter, food, transportation, utilities, clothing and how long you have been supported by this person(s) and/or agency(s).

[ ]

INCOME from (all family members)
Check all that apply **

*** If checked, you will be required to upload/provide supporting documentation*

- ☐ Wages
- ☐ Social Security
- ☐ Veterans Benefits
- ☐ SSI - Disability
- ☐ Railroad Benefits
- ☐ Self-Employment Income
- ☐ Retirement/Pension Benefits
- ☐ Child Support or Alimony
- ☐ Unemployment Compensation
- ☐ Rental Income
- ☐ Fundraisers (GoFund Me, ETC)
- ☐ Dividends/Interest/Royalties
- ☐ Military Family Allotments
- ☐ Estates/Trusts
- ☐ IRA/401K/401B Annuity Payments
- ☐ Workers Compensation
- ☐ Residential Foster Care
- ☐ Other: ____________

ASSETS: DO NOT COMPLETE FOR SISTERSVILLE RURAL HEALTH CLINICS

LIQUID ASSETS (all family members)
Check all that apply and enter amount **

- ☐ Cash ____________
- ☐ Savings Accounts ____________
- ☐ Checking Accounts ____________
- ☐ Stocks/Bonds/Certificates of Deposit ________
- ☐ Trust Fund Balance____________
- ☐ Other: ____________

Please complete all sections of this application (including signature) and include income verification, checking and savings, information for the 3 months prior to the date of service you are applying for. *Incomplete applications without income verification, checking and savings documentation will be returned to the applicant and denied until returned complete. I understand that this application (or form) is made so that the hospital can see if I am eligible for HCAP or financial assistance based on the defined criteria. If any information I have given proves to be untrue, I understand that the hospital may re-check my financial status and take whatever action is appropriate.*

Signature______________________________________ **Date** ______________

If printed, return application to: Marietta Memorial Hospital 401 Matthew Street Marietta, OH 45750 **Email: financialassistance@mhsystem.org**

PFA USE ONLY: FAMILY SIZE_______ HCAP OR UCC %_______ ____________-____________ IP/OP or OP Out of State Denied ____________

Revised 3/13/2024