Morrow County Hospital
OhioHealth

Individuals with income at or below the federal poverty guidelines are eligible for services without charge. Please see the Federal Poverty Guidelines chart to establish eligibility. To apply, complete the Financial Assistance Application and send to:

Morrow County Hospital
651 W. Marion Rd.
Mount Gilead, OH 43338

Financial assistance is available for those with income at or below 400% of the poverty guidelines and that meet other qualifications.

2024 Federal Poverty Guidelines	
	100% Discount (HCAP)
Family Size	Yearly Income Level
1	$15,060
2	$20,440
3	$25,820
4	$31,200
5	$36,580
6	$41,960
7	$47,340
8	$52,720

How to Complete the Financial Assistance Application

FIELD DESCRIPTION	DETAILS
Name/Address/Phone Number	Name, address and phone number of person completing application
Patient Account Number	Enter the account number for the initial date of service. If account number is not available, leave the box blank.
Family Members	List by name, the family members in the immediate family, including yourself (patient), patient's spouse, patient's children under 18 (natural or adoptive) who reside with the patient.
Age	List the age of each family member next to their name.
Relationship to Patient	List how this person is related to the patient. Example: Self, Spouse, Child (natural or adoptive), etc.
Source of Income or Employer Name	List the employer's name or any other source of income for this person. This would include unemployment, social security, VA, pensions, etc.
Hire/Start Date	List the start or hire date at this job, or the date the benefits began, such as with unemployment, social security, retirement, etc.
Income for 3 Months	Enter amount of gross income each person made 90 days before the service or date of application. If there is no income 90 days prior to service, enter 0.
Income for 12 Months	Enter amount of gross income each person made 12 months before the service or date of application. If there is no income 12 months prior to service, enter 0.
If $0.00 for income, provide explanation of how you were being supported (Required)	Explain your means of support (including names and phone numbers of individual(s) supporting you) since there was $0.00 income for 3 months prior to the date of service or date of application. Example: My parents supported me - Mark & Jane Smith (add phone)
Value of Assets	List any checking account money, savings, 401Ks, 403Bs, IRAs, etc. List all property, cars, boats, etc. If there are none, enter 0.
Monthly Total Expenses	Total amount of house/rent payment, car payment, utilities, food, etc.
Applicant's Signature	Sign and date the application

NOTE: Make sure account number is written at the top of all papers sent with application

HOSPITAL CARE ASSURANCE PROGRAM (HCAP) / FINANCIAL ASSISTANCE APPLICATION

Patient Name (Last) (First) (MI)	Patient Account Number
Address	Date of Service
City and State	Patient's Date of Birth
Zip Code Home Phone Number	Patient's Social Security Number

Did you have health insurance covering these services?	Yes	No
Were you an Ohio resident at the time of the hospital service?	Yes	No
Were you an active Medicaid recipient at the time of your hospital service? If yes, enter recipient billing #:	Yes	No
Are these services a result of a motor vehicle accident?	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 Member's Name	Age	Relationship to Patient	Source of Income or Employer Name	Hire/Start Date	Income for 3 months	Income for 12 months
(patient)		self				
Totals:						

Attach income verification to this application. Income verification may include pay stubs or other documents containing income information:

*If you reported $0.00 income provide an explanation of how you were being supported:

VALUE OF ASSETS

Home: Own__ Rent__ Monthly payment:$_____

Checking Account Balance: $_____ Savings Account Balance: $_____

Total Investments: $_____ Investments Description: _____

Other Assets Value: _____ $_____ $_____

Description of Assets (Car, Boat, Etc.) _____ _____ _____

Other Income: $ Other Income Description:

Monthly Total Expenses (House payment, car payment, utilities, food, etc.):

$_____

Please send the completed application to:

Morrow County Hospital
651 W. Marion Rd.
Mount Gilead, OH 43338

For further assistance or help completing this application, you may call (419) 946-5015.

I certify that the above information is true and accurate to the best of my knowledge. Further, I will apply and take any reasonable action needed to get assistance (Medicaid, Medicare, Insurance, etc.) to pay my hospital charges. Financial assistance is a source of last resort. Any other liability or possible payer will be exhausted prior to awarding assistance.

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.

Applicant Signature: _____ Date: _____

Interviewer Signature: _____ Date: _____