



Dayton Children's financial assistance program

Dayton Children's patient application for HCAP and financial assistance

For hospital use only: Approved or Denied
 Coverage span: _____

Patient name: _____ Date of service: To: _____ From: _____

Name of person completing application: _____
(if the applicant is not the patient, please answer the following questions as they apply to the patient.)

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 patient	income for 3 months prior to hospital service	income for 12 months prior to hospital 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.

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.

Patient/applicant signature: _____ Date: _____

Questions? Call 937-641-3555 or 1-800-228-4594 (Ohio only) from 8:00 am to 4:30 pm Monday - Friday.