GRACE HOSPITAL
Application for HCAP

INSTRUCTIONS

1. **List all Household Members and their Monthly Income:**

   a) List the names of everyone in the household whether they receive income from any source or not. Include yourself, any child(ren) you are applying for, any other children living in the home, your spouse, any grandparents and all other related and unrelated people living in your household. Use another piece of paper if more room is needed.

   b) List the income amount each household member received in the last month, before taxes and any other deductions and list its source(s). Possible sources include:

   Earnings from Work
   -Wages/Salaries/Tips
   -Strike Benefits
   -Unemployment Compensation
   -Worker's Compensation
   -Net Income from a Self-Owned Business or Farm

   Welfare/Child Support/Alimony
   -Public Assistance
   -Welfare Payments
   -Alimony
   -Child Support

   Pension/Retirement/Social Security
   -Pension Payments
   -Supplemental Security Income
   -Retirement Benefits
   -Veterans Payments
   -Social Security Payments

   Other Income
   -Disability Benefits
   -Cash from Savings
   -Interest/Dividends
   -Income from Estates and Trusts
   -Income for Investments
   -Income from Rents, Royalties and Annuities
   -Rental Income
   -Any other Income

   c) Supporting documentation must be included (e.g. pay stub, social security check stub, etc.). Failure to include this documentation with your application will result in a delayed or denied application.

2. **Certification:**

   a) All applications are required to have the signature of an adult household member.
   b) The application must contain the social security number of the adult household member who signs the application.

Special Note: Any changes in income or family size MUST be reported to Grace Hospital within 30 days of the change. In order to report any of the following changes the patient will contact the billing office at
These changes include:

- Family Income Changes
  - Obtaining employment, becoming self-employed, loss of employment, loss of business
  - Change in wages - increase or decrease
  - Become eligible for or ineligible for: unemployment, workers comp., disability, SSI, SSD, child support, retirement benefits
  - Bankruptcy filings
  - Become a landlord, manager or caretaker
  - Begin payment or receipt of child support
  - Change in responsibility for account
- Family Size Changes
  - Marriage, change in domestic partner living arrangements, divorce, separation, birth, death, adoption
- Medical Assistance Changes
  - Becoming eligible or being terminated from medical assistance or general assistance
- Insurance Changes
  - Begin insurance coverage, change in coverage on a child by an absent parent
- Name, Address and Phone Changes

GRACE HOSPITAL
Application for HCAP

To apply for a reduction in the price of your health care services, please complete this application, sign your name and return to: Grace Hospital, attention: Michelle Hennis, 2307 W.14th Street, Cleveland, Ohio 44113.

To process your application, it is necessary for you to include all required supporting documentation. This includes, but is not limited to, current payroll stubs, social security payment verification, letters of denial for participation in Medicaid or other health care programs, etc. Failure to include this documentation with your application may result in a denied application.

1. **List all Household Members and their Monthly Income:**

Names of all Household Members	Gross Monthly Earnings Before Deductions Job 1	Job 2	Welfare, Child Support, Alimony	Pension, Retirement Plans, Social Security	All other Sources of income
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

2. **Certification:**

I certify that all of the above information is true and correct and that all income has been included. I understand that this information is being provided to determine if I qualify for Grace Hospitals Sliding Fee Scale. I grant Grace Hospital permission to verify the information contained in this application and realize that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws. I understand that Grace Hospital will keep this information confidential except for the purposes outlined in this document.

X______________________________ ______________________________ ______________
Signature of Adult Household Member (required) *Social Security Number (required) Date

X______________________________ ______________________________
Signature of Witness Witness Printed Name

Printed Name:______________________________ Home Phone:______________

Address:______________________________ Work Phone:______________

City, State Zip:______________________________

**The Social Security Number may be used to identify the household member in our efforts to verify the accuracy of the information contained in this application. Data verification may be performed through program reviews, audits and investigations and may include employment verification for all household members. If inconsistencies between the data reported and the verified information are discovered, loss of program benefits, administrative claims and/or legal action could occur.*

DO NOT WRITE BELOW THIS LINE (For Office Use Only)

Monthly Income Conversion: Weekly x 4.33, Every 2 Weeks x 2.15, Twice a Month x 2

Total Household Size:______________ Income:______________(Monthly/Annual – circle one)

Eligibility Determination: **Approved**______________ **Rate**______________ **Denied**______________

If Denied, Reason:______________________________

Signature of Verifying Official:______________________________