# Paulding County Hospital

## HOSPITAL CARE ASSURANCE APPLICATION

Patient Name:_____ Medical Record Number: _____ Account Number:_____

Address: _____ Date of Service(s): _____ Family Member Interviewed:_____

City: _____ Patient's Date of Birth: _____ Responsible Party: _____

State: _____ Zip Code: _____ Patient's Phone #: _____ Relation to Patient: _____

During your admit date were you a resident of the State of Ohio? Yes ☐ No ☐
Era usted residente del estado de Ohio?

Did you have health insurance in at your admit date covering these services? Yes ☐ No ☐ If yes, enter information below & attach copy of insurance card
Tenia usted sequro medico para cubrir estos servicios? Si contesto si entre la informacion abajo y incluya copia de la tarjeta del seguro.

Name of Insurance Co. _____ Policy #_____ Group #_____
Nombre de la Compañía de Seguro Medico. No. de poliza No. de grupo

Did you have Medicaid benefits at your admit date Yes ☐ No ☐ If yes, enter billing #_____ & attach copy of Medicaid card
Tenia usted beneficios de Medicaid? Si responde si, anote el # de tarjeta e incluya una copia de la tarjeta de Medicaid

Did you have Disability Assistance (DA) benefits at your admit date? Yes☐ No ☐ If yes, enter billing #_____ & attach copy of DA card
Tenia usted beneficios del Programa de Asistencia por Inpedimentos (DA)? Si responde si, anote el # de tarjeta e incluya una copia de la tarjeta de DA

**Please list all "family" members (including yourself). Family members include parents, spouses (regardless of whether they live in the home) & children (natural or adoptive) under the age of eighteen (18) living in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, social security benefits, public assistance, etc.**
Liste por favor a todos los miembros de la familia (inclusive usted mismo). Los miembros de la familia incluyen a padres, los esposos (a pesar de si ellos viven en el hogar) & niños (natural o adoptivo) bajo la edad de dieciocho (18) viviendo en el hogar *junto con el paciente. Los ingresos incluyen grueso (antes de impuestos) los sueldos, los ingresos de la renta, compensacion de desempleado, los beneficios de seguro social, asistencia publica, etc.*

| Family Members<br>Miembros de Familia | Age as of<br>Edad | Relationship to Patient<br>Relación con el paciente | Source of Income or Employer Name<br>Fuente de Ingreso o Nombre del Empleador | Income from 3 months prior to the date of service<br>Ingreso de tres meses antes de la fecha de servicio | Income from 12 months prior to the date of service<br>Ingreso de doce meses antes de la fecha de servicio |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| TOTALS | | | | | |

**NOTE: If any of the family members had no income during the above time periods, please mark "NONE" as the income source and place 0.00 as the income**
**NOTA: Si cualquiera de los miembros de la familia no tuvo ingresos durante los períodos de tiempo mencionados, marque por favor "NINGUNO" como la fuente de ingresos y coloque 0.00 como los ingresos**

**If you reported $0.00 or no income above, please provide a brief explanation below of how you (or the patient) survived financially during the above time period.** *Si usted informó $0.00 o ningun ingreso arriba, por favor proporcione una explicación breve de cómo usted (o el paciente) sobrevivio financieramente durante el período de tiempo mencionado.*

_____

I affirm that the answers on this application are true, and I understand that it is unlawful to knowingly submit false information to obtain government benefits.
Afirmo que las respuestas en esta aplicación son verdad, y yo entiendo que es ilegal someter consientemente información falsa para obtener los beneficios del gobierno

Applicant Signature: _____ Date Completed: _____
Firma de la persona responsable Fecha Actual

**A new or updated application is required for each month in which services are provided.**

# STATE FISCAL YEAR 2026 FINANCIAL ASSISTANCE GUIDELINES

| Persons in Family Unit | 100% Assistance "HCAP" | 90% Assistance | 80% Assistance | 70% Assistance | 60% Assistance | 50% Assistance | 40% Assistance | 30% Assistance | 20% Assistance | 10% Assistance |
|---|---|---|---|---|---|---|---|---|---|---|
| *1* | *$15,960* | *$17,556* | *$19,152* | *$20,748* | *$22,344* | *$23,940* | *$25,536* | *$27,132* | *$28,728* | *$30,324* |
| *2* | *$21,640* | *$23,804* | *$25,968* | *$28,132* | *$30,296* | *$32,460* | *$34,624* | *$36,788* | *$38,952* | *$41,116* |
| *3* | *$27,320* | *$30,052* | *$32,784* | *$35,516* | *$38,248* | *$40,980* | *$43,712* | *$46,444* | *$49,176* | *$51,908* |
| *4* | *$33,000* | *$36,300* | *$39,600* | *$42,900* | *$46,200* | *$49,500* | *$52,800* | *$56,100* | *$59,400* | *$62,700* |
| *5* | *$38,680* | *$42,548* | *$46,416* | *$50,284* | *$54,152* | *$58,020* | *$61,888* | *$65,756* | *$69,624* | *$73,492* |
| *6* | *$44,360* | *$48,796* | *$53,232* | *$57,668* | *$62,104* | *$66,540* | *$70,976* | *$75,412* | *$79,848* | *$84,284* |
| *7* | *$50,040* | *$55,044* | *$60,048* | *$65,052* | *$70,056* | *$75,060* | *$80,064* | *$85,068* | *$90,072* | *$95,076* |
| *8* | *$55,720* | *$61,292* | *$66,864* | *$72,436* | *$78,008* | *$83,580* | *$89,152* | *$94,724* | *$100,296* | *$105,868* |
| **For each additional person add** | **$5,680** | **$6,248** | **$6,816** | **$7,384** | **$7,952** | **$8,520** | **$9,088** | **$9,656** | **$10,224** | **$10,792** |