GRAND LAKE™
HEALTH SYSTEM

200 St. Clair Street * St. Marys, Ohio 45885 * (419) 394-3335

May 28, 2025

Dear HCAP/Financial Assistance Applicant:

Enclosed is an application for the Hospital Care Assurance Program (HCAP)/Financial Assistance Program offered by Grand Lake Health System. If you are over income guidelines for free care, but are experiencing financial hardship, you will be considered for reduced cost care based on your household size and income.

Please complete the enclosed application and provide reliable evidence documenting your income for either three or 12 months prior to your date of service. For example, if your initial date of service was July 15, 2022, then we will either need proof of income from April 15, 2022 through July 15, 2022 or July 16, 2021 to July 15, 2022. If you provide documentation of income for three months prior to your date of service, we will multiply this income by four to project your annual income.

Proof can be in the form of pay stubs, social security/disability income benefit statements, unemployment/worker's compensation, or other documents containing income information for the appropriate time period. If you have no income or if you are self-employed, please contact our office and we will supply you with the appropriate forms that will need to be completed. Proof of income needs to be returned within 30 days or your application may be denied.

If you should have any questions, please do not hesitate to contact us. Our Financial Counselor is available Monday through Friday, 8:00 a.m. to 4:30 p.m. at 419-394-8389.

Thank you for choosing Grand Lake Health System for your health care needs.

Sincerely,

Financial Counselor

Grand Lake Health System HCAP/Financial Assistance Application

Patient Name:	Date of Application:
Applicant Name (if not the patient):	

*If the applicant is not the patient, please complete the application as it applies to the patient for the date of service you are applying for

Street Address:	City:	State:	Zip Code:

Account Numbers(s):	Date of Service: From: To:

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, Medicaid Recipient Number:		
Did you have health insurance (other than Medicaid) at the time of your hospital service?	Yes	No
If yes, please name the insurance type:		

Please provide the following information for all the people in your immediate family who live in your home.

For purposes of HCAP/Financial Assistance, "family" shall include:

- the patient, the patient's spouse (regardless of whether they live in the home), and all of the patient's children, natural or adoptive, under the age of eighteen who live in the home.
- if the patient is under the age of eighteen, "family" shall include the patient, the patient's natural or adoptive parent(s) (regardless of whether they live in the home), and the parent(s)' children, natural or adoptive under the age of eighteen who live in the home.
- if the patient is the child of a minor parent who still resides in the home of the patient's grandparents, the "family" shall include only the parent(s), and any of the parent(s)' children, natural or adoptive who reside in the home.

Name	Birthdate	Relationship to Patient	Income for 3 months prior to date of service	Income for 12 months prior to date of service	Income verification attached	
			$	$	Yes	No
			$	$	Yes	No
			$	$	Yes	No
			$	$	Yes	No
			$	$	Yes	No
			$	$	Yes	No

Marital status on Date of Service:	Single	Engaged	Married	Separated	Divorced	Widowed

*** Income amounts for the 3 months and 12 months prior to the date of service must be provided above.**

**** To verify income, documentation must be provided with this application; documentation will not be returned.**

For purposes of HCAP/Financial Assistance, "Income" is defined as:

- Total salaries, wages, and cash receipts before taxes or deductions are taken.
- Self-employment revenue less reasonable business expenses.

Income verification may include:

- Pay Stubs, Social Security/Disability Income, Unemployment/Worker's Compensation, Self-Employment Form, or other documents containing income information for the appropriate time period (3 or 12 months prior to the date of service). Individuals with Social Security/Disability Income must provide a copy of their benefits statement.

- **If you reported $0 income, a Letter of Support must be completed.**

INCOME DOCUMENTATION IS ATTACHED	**YES □**

By my signature below, I certify that everything I have stated on this application and on any attachments is true.

Applicant Signature	Date

***Return to: Grand Lake Health System · Attn: Financial Counselor · 200 St. Clair Street · St. Marys, Ohio 45885-2400**