SALEM REGIONAL MEDICAL CENTER

The entire application, including signature must be completed and signed to be considered. For assistance, call 330-332-7601.

HOSPITAL CARE ASSURANCE PROGRAM - HCAP

Patient Name (Last) (First) (MI)	
Address	
City and State	Patient's Date of Birth
Zip Code Phone Number	Patient's Social Security Number
Date(s) of Hospital Services:	Account number if known:

Was there health insurance coverage for the services? Yes No Name of Insurance Company: Policy ID:

Were you an Ohio resident at the time of the service? Yes No Were you a U.S. citizen at the time of your service? Yes No

Were you an active Medicaid recipient at the time of your hospital service? No Yes, Recipient or ID #

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 Members Name	Age	Relationship to Patient	Gross Income total for one (1) month prior to hospital service*	Gross Income total for three (3) months prior to hospital service*	Gross Income for one year (12) months prior to hospital service*
(patient)		self			
Total person in family:			Total family Income:		

Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security benefits, public assistance, child support, etc.

If you reported $0.00 income above, please have the Support Statement below completed by the person(s) helping to support you and/or your family.

I hereby certify and verify that all of the foregoing information given is true and correct to the best of my knowledge and belief. I understand that my signature does not oblige me to be financially responsible for charges rendered to the person for whom I am providing basic financial support.

Signature of person providing financial support to applicant Date

By my signature below, I certify that everything I have stated on this application and on any attachments are true. I will apply and take any reasonable action needed to get assistance to pay my hospital charges including Medicaid, Medicare, other liability or possible payer prior to awarding assistance.

Applicant Signature: Relationship to patient Date:

SRMC Representative Signature Date:

Please send completed applications to Salem Regional Medical Center, Attention HCAP: 1995 East State Street, Salem, OH 44460

(4/2026)