



6847 N. Chestnut Street  
P.O. Box 1204  
Ravenna, Ohio 44266

Phone (330) 297-0811

- All patients are entitled to receive basic, medically necessary hospital services without charge, if the total household 12 month income is at or below the Federal Poverty Guidelines
- Patient must be a resident of the State of Ohio to qualify for the HCAP program
- Only Portage County residents can qualify for a partial discount available through the RPAP program with household income up to 3 times the Federal Poverty Guidelines
- There is no cost for this program
- Only Robinson Health Affiliate Physician services are covered under the RPAP program.  
**NO** Physician services are covered under the HCAP program
- New application is required every 45 days for Inpatient services and 90 days for Outpatient services
- Proof of income is required for eligibility 3 month or 12 month prior to the date of service, Prior years tax return for Self Employed
- HCAP and RPAP are not an insurance
- Insurance Deductibles are eligible for HCAP and RPAP under Robinson Memorial Hospital Program ONLY
- If you qualify for Medicaid or Medicaid HMO you will not qualify for HCAP or RPAP
- Family is defined as the patient, the patient's spouse and all of the patient's children (natural or adoptive but does not include stepchildren) under age 18

**2009 FEDERAL POVERTY INCOME GUIDELINES 01/23/2009 RHA for dates of service on or after 03/01/2010**

	100% HCAP	130%	150%	200%	250%	300%
Family Size	Family Income	Family Income	Family Income	Family Income	Family Income	Family Income
1	0 - 10,830	10,831-14,079	14,080 – 16,245	16,246 – 21,660	21,661 – 27,075	27,076 – 32,490
2	0 – 14,570	14,571-18,941	18,942 – 21,855	21,856 – 29,140	29,141 – 36,425	36,426 – 43,710
3	0 – 18,310	18,311- 23,803	23,804 – 27,465	27,466 – 36,620	36,621 – 45,775	45,776 - 54,930
4	0 – 22,050	22,051–28,665	28,666 – 33,075	33,076 – 44,100	44,101 – 55,125	55,126 – 66,150
5	0 – 25,790	25,791- 33,527	33,528 – 38,685	38,686 – 51,580	51,581 – 64,475	64,476 – 77,370
6	0 – 29,530	29,531- 38,389	38390 – 44,295	44,296 – 59,060	59,061 – 73,825	73,826 – 88,590
RMH No Insurance Discount	100%	100%	100%	75%	50%	25%
RMH W / Insurance Discount	100%	SAME AS 150%	75%	50%	25%	NONE
RHA No Insurance Discount	60% *	50% *	40% *	20% *	NONE	NONE
RHA w/Insurance NO Discount	N/A	NONE	NONE	NONE	NONE	NONE

Add \$3,740 for each additional family member

www.robinsonmemorial.org



# HOSPITAL CARE ASSURANCE PROGRAM APPLICATION

Please call 330-297-2338 to schedule an appointment with a Financial Counselor: Monday – Friday 8:30am – 8pm

PATIENT # \_\_\_\_\_  
Month of Service \_\_\_\_\_

Patient Last Name, First Name, MI	Responsible Party, if patient under 18	Phone Number ( )	Patient Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
Patient Address – Apt or Lot #	City, State and Zip Code	County of Residence	
Patient's Social Security Number	Patient's Date of Birth		
<b>PATIENT</b> or Mother if patient under 18 Employer Name:	Hire Date – Month/Day/Year _____ Last Date worked _____ <input type="checkbox"/> Never Worked – Complete statement of living*	Income from Employer: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly \$ _____	
<b>SPOUSE</b> or Father if patient under 18 Employer Name:	Hire Date – Month/Day/Year _____ Last Date Worked _____ <input type="checkbox"/> Never Worked - Complete statement of living*	Income from Employer: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly \$ _____	

**Does the patient have health insurance for these services?** Yes  No   
Does the patient have Medicaid/Disability Assistance for this date of service? Yes  No  Applied

Family Member Names	Date of Birth MM/DD/YEAR	Relationship to Patient	Source of Income or Employer Name	Gross income for 3 months before date of service
1. <b>PATIENT</b>		<b>SELF</b>		
2.				
3.				
4.				
5.				

Attach additional sheet if necessary. Same information must be provided as above for additional family members.

\* If \$0.00 income is reported, you must provide a brief explanation below of how the patient/household survived financially during the 3 or 12 months before the month of service. **LAST DATE WORKED :** \_\_\_\_\_

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

**X** \_\_\_\_\_  
Patient or applicant signature

\_\_\_\_\_  
Date of signature

**Attach copies of:** \_\_\_\_\_

- Last 3 months pay stubs before date of service
- Unemployment
- Workers' Compensation
- Alimony / Child Support
- Social Security / Pension \_\_\_\_\_
- Self Employed Current Year Tax Return \_\_\_\_\_
- Any other source of income before date of service

**Please bring this Application and  
income to your appointment with  
with the Financial Counselor**