Cleveland Clinic

Summary of Financial Assistance

Ohio Hospital Care Assurance Program (HCAP). As a participant in the HCAP Program, we offer emergency and other medically necessary hospital-level services free of charge if you are a resident of Ohio and either (1) you are currently an eligible recipient of the General Assistance or the Disability Assistance Programs or (2) your income is at or below 100% of the Federal Poverty Guidelines (the FPG).

Our General Financial Assistance Policy. In addition to HCAP, under our facility's Financial Assistance Policy, we provide financial assistance for emergency and other medically necessary care on a sliding scale discount from our normal charges if you are a resident of the state in which you are seeking care (Ohio, Florida or Nevada), do not have insurance, and your family income does not exceed four times the FPG. If you are a Florida resident, you must reside in either Broward or Palm Beach Counties to be eligible for assistance. If you are a Nevada resident, you must reside within a 150 mile radius of the facility at which you are seeking care. All applicants will be screened for Medicaid coverage and must cooperate with the Medicaid representatives to be eligible for assistance under our financial assistance policy. If you are eligible for financial assistance under our Policy, you will receive free or other discounted assistance according to the following sliding scale:

Annual Family Income	Amount of Discount
Less than 250% FPG	100%
251–300% FPG	75%
301–350% FPG	50%
351–400% FPG	35%

Exceptional Medical Circumstances. Even if your family income exceeds 400% of the FPG, if you supply information to support exceptional medical circumstances (for example, terminal illness, excessive medical bills and/or medications, etc.), you will be considered on a case-by-case basis for assistance if 100% of incurred charges for your care are greater than 25% of your annual family income.

Other Assistance. If you are pregnant and your insurance does not provide maternity benefits, you may be eligible for assistance under our Policy, provided that you meet the Policy income requirements and agree to work with us to determine if you are eligible for maternity benefits under a governmental program. If your insurance does not provide coverage for your services, if you have exhausted your lifetime maximum insurance benefits, or if you have a pre-existing condition not covered by your insurance, and if you meet the income criteria, you are eligible for assistance under our Policy. If you are an organ donor, you will be considered under the organ recipient's Application for Financial Assistance.

Charges Will Not Exceed Amounts Generally Billed to Medicare

If you receive an award of financial assistance under our Policy and your award does not cover 100% of our charges for the service, you will not be charged more for emergency or other medically necessary care than the amount we generally bill patients having insurance under Medicare.

How to Obtain Copies of Our Financial Assistance Policy

You may obtain a copy of our Policy and the Financial Assistance Application Form: (i) on the Cleveland Clinic's website at www.ccf.org/financialassistance, and (ii) in our admission packet, in our emergency departments, or in any of our financial counselor or cashier's offices. In addition, if you provide your mailing address to a financial counselor or customer service representative, we will mail you a copy of our Financial Assistance Policy and Application Form free of charge.

How to Obtain Information and Assistance Regarding Our Financial Assistance Policy

For information regarding our Financial Assistance Policy and Financial Assistance Application Form, please contact our financial counselors located at any of our locations, or Customer Service at 866.621.6385 or any of our Medicaid representatives.

Copies of our Financial Assistance Policy, Application Form, and this Summary are available in English, Arabic and Spanish.

Las copias de nuestra Política de ayuda financiera, el Formulario de solicitud y el presente Resumen están disponibles en español.

تتوفر نسخ من سياسة المساعدة المالية وهذا الملخص باللغة العربية.

Return your completed application to: **Revenue Cycle Management – Cleveland Clinic**
6801 Brecksville Rd., RK2-3, Independence, OH 44131-9980

Cleveland Clinic

Financial Assistance Application Form

SECTION ONE: PATIENT INFORMATION

Print your full name, your address at the time you received medical service and other information noted in this section.

Facility: ❑ Cleveland Clinic Main Campus or Family Health Center ❑ Cleveland Clinic Florida ❑ Lou Ruvo
❑ Euclid ❑ Fairview ❑ Hillcrest ❑ Lakewood ❑ Lutheran ❑ Marymount ❑ Medina ❑ South Pointe

Account Number _____ Date(s) of Service _____

Name: _____
LAST FIRST MIDDLE INITIAL

Address: _____ City _____ County: _____
NUMBER AND STREET

State of Residence: _____ Zip Code: _____ Social Security Number: ____/____/_____ Date of Birth: ____/____/____

Marital Status: ❑ Single ❑ Married ❑ Divorced Home Phone No.: (_____) _____ Other Phone No.: (_____) _____

Are you a legal resident of the United States? ❑ Yes ❑ No

Did you have health insurance (other than Medicaid) at the time of your service? If yes, please provide your insurance information and a copy of your insurance card. ❑ Yes ❑ No

Name of insurance: _____ Effective date of insurance: ____/____/____

Subscriber Name: _____ Subscriber ID: _____ Group Number: _____

SECTION TWO: FAMILY INCOME

Provide income for yourself, your spouse and all other family members (if applicable.)

Monthly Income Source	Current Monthly Gross Income Amount Patient	Current Monthly Gross Income Amount Spouse/Other	Total Family Income for 3 months prior to date of service	Type of Income verification attached – proof of income is requested to process your application
Wages/Self Employment, Child support and alimony	$	$	$	Copy of most recent pay stubs or income award letters (for three previous months.)
Social Security	$	$	$	Social Security award letter
Pension, Dividends, Interest, Rental Income	$	$	$	Pension benefits letter, Dividend/Interest Statement
Unemployment, Workers' Compensation	$	$	$	Unemployment benefit letter, Workers' Compensation benefit letter

If you reported $0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs:

_____

SECTION THREE: FAMILY INFORMATION

List all family members in your household named on the most recent federal income tax return, and their date of birth.

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of HCAP, family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Name of family members, including patient Date of Birth Relationship to Patient

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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

Responsible Party Signature: x _____ Date: _____

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