

Summary of Financial Assistance

Ohio Hospital Care Assurance Program (HCAP)

As a participant in the HCAP Program, we offer emergency and other medically necessary services in our hospitals 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).

The following is a summary of financial assistance available at Cleveland Clinic Akron General and its facilities including Lodi Community Hospital, and Edwin Shaw Rehabilitation Institute.

Financial Assistance Offered

If you do not have insurance, we provide financial assistance for emergency and other medically necessary care as a discount from our normal charges if your family income does not exceed four times the FPG and you are a resident of the state of Ohio. All applicants will be screened for Medicaid coverage and must cooperate with the Medicaid application process to be considered for financial assistance. If you are eligible for financial assistance under our Policy, you will receive free or discounted assistance according to the following income criteria:

- If your annual family income is up to 250% of the FPG, you will receive free care,
- If your annual family income is between 251% and 400% of the FPG, you will receive care discounted to the amount we generally bill insured patients for such services.

Even if you have insurance, as long as you meet our income criteria, you will be eligible for financial assistance if:

- your insurance does not provide coverage for the medically necessary services you are seeking, or
- you have exhausted your lifetime maximum insurance benefits.

Additional Ways to Qualify

If you do not meet the income criteria above, regardless of your insurance status or state of residence, you will be considered on a case-by-case basis for financial assistance under the following circumstances:

Catastrophic Balance - If you have a balance due to an AGMC facility of greater than 15 % of your annual family income, you will be considered for financial assistance.

Exceptional Circumstances - If you have an extreme personal or financial hardship, you may contact us to be considered for financial assistance.

Specific Medical Circumstances - If you are seeking treatment that can only be provided by Akron General medical staff or you would benefit from continued medical services from Akron General for continuity of care, you will be considered on a case by case basis for financial assistance for that specific treatment.

Maternity Care

If you are pregnant and your insurance does not provide maternity benefits, you will be eligible for financial assistance under our Policy, as long as you meet our income criteria, are an Ohio resident and agree to work with us to determine if you are eligible for maternity benefits under a governmental program.

Charges Will Not Exceed Amounts Generally Billed

If you receive financial assistance under our Policy, you will not be charged more for emergency or other medically necessary care than the amount we generally bill patients having commercial insurance or Medicare coverage.

How to Obtain Copies of Our Policy and Application

You may obtain a copy of our Policy and the Financial Assistance application form: (1) on the Akron General website at www.akrongeneral.org/financialpolicyexpanded, and (2) in our admissions areas, in our emergency departments, or in any of our financial counselor's offices. If you call Patient Financial Services at 330-344-2000 or ask a financial counselor, we will mail you a copy of our Financial Assistance Policy, plain language summary and application form free of charge.

How to Apply and Obtain Assistance

You may apply at any point in the scheduling or billing process by completing and submitting an application and providing income information. Any Financial Assistance Application whether completed in person, delivered or mailed in, will be forwarded to the Patient Financial Services team for evaluation and processing. If you think you may have catastrophic, exceptional or special medical circumstances, a financial counselor or Patient Financial Services representative can initiate an application for you. If you need any help in applying, please contact our financial counselors located at our facilities or call Patient Financial Services at 330-344-2000.

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

Return your completed application to:

Patient Financial Services - Akron General Medical Center, 1 Akron General Avenue, Akron, OH 44307

SECTION ONE: PATIENT INFORMATION

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

Account Number: _____ Date(s) of Service: _____

Patient Name (Last, First, M.): _____

Address: _____ City: _____

County: _____ State: _____ Zip: _____ Date of Birth: _____

Marital Status: Single Married Divorced Email: _____

Primary Phone Number: _____ Home Mobile Work Other: _____

Health Insurance during date of service: None Medicare Medicaid Other: _____

SECTION TWO: FAMILY INCOME

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

Income Source	Total for 3 months prior to service	Total for 12 months prior to service
Wages / Self Employment	\$	\$
Social Security	\$	\$
Pension, Dividends, Interest, Rental Income	\$	\$
Unemployment, Workers Compensation	\$	\$
Child Support (only if patient is intended recipient)	\$	\$
Other	\$	\$

SECTION THREE: FAMILY INFORMATION

List all family members in your household 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 the patients children under 18 (natural or adopted) who live in the patients 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 and adopted) who live in the patients home.

Name of family member, including patient	Date of Birth	Relationship to patient
Patient:		

By signing below, I certify that everything I have stated on this application / attachment(s) is true.

Patient / Responsible Party Signature: _____ Date: _____

Return your completed application to:
Patient Financial Services, Cleveland Clinic Akron General
1 Akron General Ave, Akron, OH 44307