Cleveland Clinic

FINANCIAL ASSISTANCE PROGRAM

Under the Ohio Hospital Care Assurance Program (HCAP), Cleveland Clinic and its hospitals and family health centers offer basic, medically necessary hospital-level services free of charge to individuals who are residents of Ohio, and who are currently eligible recipients of the General Assistance or the Disability Assistance Programs or whose income is at or below the Federal Poverty Income Guidelines.

In addition to the HCAP program, we provide financial assistance on a sliding scale to patients who do not have insurance at family income levels up to four (4) times the Federal Poverty Guidelines, and to all patients, including patients with insurance coverage, if there are exceptional circumstances.

2009 Federal Poverty Income Guidelines*

Family Size	**(HCAP) 2008 Federal Poverty Income Level*	*CC Financial Assistance Program (Family income up to 400% of Federal Poverty Level)*
1	**$10,830**	**$43,320**
2	**14,.570**	**58,280**
3	**18,310**	**73,240**
4	**22,050**	**88,200**
5	**25,790**	**103,160**
6	**29,530**	**118,120**
7	**33,270**	**133,080**
8	**37,010**	**148,040**
For each additional family member add $3,740		

If you receive medical services at Cleveland Clinic or its hospitals or family health centers and feel you qualify to receive these services without cost or at a reduced cost to you, please complete this application and return it to:

Si usted tiene preguntas en relacion con el programa de ayuda financiera de Cleveland Clinic favor de llamar al #1-866-737-4358, opcion 2.

Patient Financial Services – Cleveland Clinic
9500 Euclid Avenue
Mailcode: ST-02
Cleveland, OH 44195

Dear Patient,

The Cleveland Clinic Financial Assistance Program may be able to help you with hospital-related expenses for services performed at Main Campus, our Community Hospitals, and Weston Hospital in Florida.

If you are seen at Main Campus or one of our Family Health Centers, the Cleveland Clinic Financial Assistance Program also may provide help with your physician- related expenses.

The Cleveland Clinic Financial Assistance Program will not provide assistance for expenses for your physician (including but not limited to your personal physician, the radiologist, pathologist, anesthesiologist and emergency room physician) if you are seen at one of our community hospitals (Hillcrest, Euclid, Huron, South Pointe, Fairview, Lakewood, Lutheran, or Marymount.)

IMPORTANT

Before we consider your application for Financial Assistance, we will provide you with a free service to determine if you are eligible for free medical coverage from different State programs. Once a determination is made that you are not eligible for a State program, we will extend financial assistance based on your household income and family size.

In order to provide you with help under the Cleveland Clinic Financial Assistance Program, you must cooperate completely with the free service we provide you to determine eligibility for medical coverage from the State.

COMPLETING THE APPLICATION FOR FINANCIAL ASSISTANCE

Your application MUST be signed and complete or your application will be denied.

In order to determine eligibility for HCAP or Financial Assistance, we look at your family income and size, and available assets.

Eligibility for HCAP

1. You must be a resident of the state of Ohio
2. You must be at or below 100% of the Federal Poverty Income Guidelines in the 3 month period prior to date of service.
3. Family members include you, your spouse and/or natural/adopted children under the age of 18 living at home.

Eligibility for Cleveland Clinic Financial Assistance

1. You must be a legal resident of the United States.
2. You must be between 101% - 400% of the Federal Poverty Income Guidelines.
3. Family members include individuals listed as your dependents on the most recently filed federal income tax return.
4. You must provide proof of income (income includes gross wages, rental income, gross income from self employment, public assistance, social security, unemployment compensation, strike benefits, alimony, child support, military family allotments, pensions, veteran's benefits, etc..) Sources of income apply to all applicable family members. Use the checklist below to make sure you return an acceptable form of proof of income with your application:

_____ Income Tax Return
_____ Copy of most recent W-2's
_____ Copy of recent pay stubs
_____ Social Security award letter
_____ Pension benefits letter

Please detach this portion of the application to keep for your records.

Cleveland Clinic

FINANCIAL ASSISTANCE APPLICATION FORM

Please read carefully the instructions on page 2 before completing this form.

Section One: Requested Services – check the services for which you are requesting financial assistance and include account numbers.

□ *Cleveland Clinic Main Campus* _____

□ *Euclid* _____

□ *Fairview* _____

□ *Huron* _____

□ *Lakewood* _____

□ *Marymount* _____

□ *Lutheran* _____

□ *Cleveland Clinic Florida* _____

□ *Hillcrest* _____

□ *South Pointe* _____

□ *Medina* _____

Section Two: Patient Information – please print your full name, address, and other information.

Name: (Last) _____ (First) _____ (Middle Initial)_____

Address: (Number and Street)_____

City: _____**State of Residence**: (at time of service)_____ **Zip**: _____

Social Security Number: ____-___-____ **Marital Status: Single ___ Married___ Divorced ___**

Date(s) of Service: _____

Date of Birth: ____/____/____**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 a copy of your insurance card. Yes ____ No ____

Section Three: 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 required to process your application
Wages/Self Employment Child support and alimony	$	$	$	Most Recent Income Tax Return, Copy of most recent W-2's, copy of pay stubs (for 3 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 needs:

_____

_____

_____

Section Four: 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 eighteen, 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		
7		
8		

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: _____