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 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 all Cleveland Clinic facilities including its hospitals and family health centers. This summary is not applicable to Cleveland Clinic Rehabilitation Hospitals, Select Cleveland Hospitals, Ashtabula County Medical Center facilities, and Union Hospital, which have their own financial assistance policies.

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 in which you are seeking care (Ohio, Florida or Nevada). If you are a Florida resident, you must be a resident of the following counties: Broward, Indian River, Martin or South St. Lucie and seeking emergency services or medically necessary care (Southeast Florida Facilities cover emergency care services only). All applicants will be screened for Medicaid coverage and must cooperate with the Medicaid representatives 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.
- For East Central Florida facilities only: Uninsured patients who do not otherwise qualify for financial assistance are eligible for a discount of 50% off gross charges.

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 Cleveland Clinic 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.
- *Special Medical Circumstances.* If you are seeking treatment that can only be provided by CCHS medical staff or you would benefit from continued medical services from CCHS for continuity of care, you will be considered on a case-by-case basis for financial assistance for that specific treatment. If you are seeking treatment in Florida, you must be an existing patient of a CC Florida physician.

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 or a Florida resident of either Indian River, Martin or South St. Lucie County, 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 Cleveland Clinic's website at www.ccf.org/financialassistance, and (2) in our admissions areas, in our emergency departments, or in any of our Patient Financial Advocate's offices. If you call Patients First Support Services at 772.567.4311 x1169 or ask a Patient Financial Advocate, 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, online, delivered or mailed in, will be forwarded to the Patients First Support Services team for evaluation and processing. If you think you may have catastrophic, exceptional or special medical circumstances, a Patient Financial Advocate or Patients First Support Services representative can initiate an application for you. If you need any help in applying, please contact our Patient Financial Advocates located at our facilities or call Patients First Support Services at 772.567.4311 x1169.

Copies of our Financial Assistance Policy, Application Form, and this Summary are available in English, Arabic, Spanish, and Creole.
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 ونموذج الطلب وهذا الملخص باللغة العربية.

Return your completed application to: **Patients First Support Services – Cleveland Clinic**
1000 36th Street, Vero Beach, FL 32960 or email to FASU@IRMC.CC

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.

Account Number _____ Date(s) of Service _____

Patient Name: _____ _____ _____
LAST FIRST MIDDLE INITIAL

Address: _____ _____ _____
NUMBER AND STREET CITY COUNTRY

State of Residence: _____ Zip Code: _____ Date of Birth: ____ /____ /_____ Marital Status: Single

PrimaryPhoneNumber: (_____) _____ ☐ Home ☐ Mobile ☐ Work ☐ Other _____

Email Address: _____

Health insurance at time of date of service: No Insurance _____

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	Duration
Wages/Self Employment	$	$	Monthly
Social Security	$	$	Monthly
Pension, Dividends, Interest, Rental Income	$	$	Monthly
Unemployment, Workers' Compensation	$	$	Monthly
Child Support (only if the patient is the intended recipient)	$	$	Monthly
Other	$	$	

SECTION THREE: FAMILY INFORMATION AND INCOME

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. 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 paren (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. Patient:		
2.		
3.		
4.		
5.		
6.		

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

Responsible Party Signature: x _____ Date: _____

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MEDICAID SCREENING QUESTIONNAIRE GUIDE

Name:_____ **Account #:** _____

Address:_____ **Date of Service:** _____

DOB:_____ **SSN:** _____

What telephone # and time of day best to contact: tele #_____ **time:**_____

1. Does the patient have insurance? YES ◯ NO ◯
   If the answer to this question is YES **DO NOT REFER!!!**
2. Has the FAP applications been secured? YES ◯ NO ◯

MEDICAID FOR WOMEN, CHILDREN AND FAMILY PROGRAMS – If yes to any question, refer immediately.

1. Is the patient under the age of 18? YES ◯ NO ◯
2. Is the patient between ages 18 and under 21? YES ◯ NO ◯
3. Is the patient pregnant? YES ◯ NO ◯
4. Does the patient have any biological or adoptive children in household under 18 years of age? YES ◯ NO ◯

MEDICAID FOR THE AGED, BLIND, & DISABLED – If yes to any question, refer immediately.

1. Is the patient currently receiving SSI or SSD? YES ◯ NO ◯
2. Does the patient have any of the following conditions: YES ◯ NO ◯
   - Total Deafness
   - Total Blindness
   - Confinement to bed or wheelchair due to condition.
   - A stroke occurring three months ago, resulting in inability to walk independently.
   - Amputation of leg at hip
   - Cerebral Palsy, Muscular Dystrophy, or Muscular Atrophy, Down Syndrome
   - Requires hospice care for cancer
   - Severe prematurity
   - Spinal Injury resulting in the inability to walk.
3. Is the patient 65 or older and not on Medicare? YES ◯ NO ◯
4. Have you been deemed Disabled by a Physician for at least a year? YES ◯ NO ◯

IF THE ANSWER IS YES TO ANY OF THE ABOVE QUESTIONS, REFER ACCOUNT TO FASU FOR MEDICAID ELIGIBILITY ASSISTANCE. MAKE SURE TO SEND THE COMPLETED, SIGNED APPLICATION FOR FINANCIAL ASSISTANCE WITH THIS REFERRAL.

Patient has the following previous dates of service: _____

Person Referring Account _____ Extension _____

Email it to FASU @IRMC.CC Dept. Code # ED/ER

Cleveland Clinic

Public Assistance Consent & Authorization to Release Information

Patient Name _____ Medical Record Number _____

Social Security Number _____ Date of Birth _____

I authorize Cleveland Clinic Indian River Hospital to act as my designated representative in establishing eligibility for any and all programs for which I may be considered. This authorization includes securing information from and providing to, the Department of Children and Family Services and the Social Security Administration. Cleveland Clinic Indian River Hospital is authorized to act on behalf to request and represent me at hearings, conferences, and/or other meetings that pertain to me. I hereby authorize the release of the following information:

Information to be released: (check all that apply)

✓ Social Security Administration
✓ Employment Verification/Payroll Records
✓ Insurance Policy Verification
✓ Pension/Retirement Verification
✓ Worker's Comp Verification
✓ Food stamp eligible months and amount
✓ Department of Family and Children Services
✓ Bank or Credit Union Account Verification
✓ Household Verification
✓ VA Benefits Verification
✓ Medical Records from Treating Facility
✓ Assets

A copy or fax of this authorization will serve as the original. I understand that I may revoke this authorization at any time by saying so in writing with the date and my signature. Any information released before the time of cancellation cannot be revoked, the facility, its employees, and physicians are hereby released from and legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature: _____ email to FASU@IRMC.CC

Date: _____ Case Number: _____

Agency Information:	
ESS Specialist's Name: _____ ESS Specialist's Signature: _____ Date: _____	Office Address/Phone Number: