

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, and Ashtabula Regional Medical Center facilities 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 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.

Even if you have insurance, as long as you meet our income criteria, you will be eligible for financial assistance if: your in-network 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 on charges from an episode of care greater than 25% of your annual family income, you will be considered for financial assistance. (This excludes patients with insurance where Cleveland Clinic is out-of-network or non-contracted).

- **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 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, Medicare, or Medicaid 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 Customer Service at 866.621.6385 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 Revenue Cycle Management team for evaluation and processing. If you think you may have catastrophic, exceptional or special medical circumstances, a Patient Financial Advocate or Customer Service 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 Customer Service at 866.621.6385.

Copies of our Financial Assistance Policy, Application Form, and this Summary are available in English, Arabic, Spanish, Russian, Ukrainian, Nepali, Haitian Creole, and Creole. | Las copias de nuestra Política de Asistencia Financiera, el Formulario de solicitud y el presente Resumen están disponibles en inglés, árabe, español, ruso, ucraniano, nepalí, criollo haitiano y creole. | Копії Політики оказання фінансової допомоги, бланка заявки та цього Короткого огляду доступні на англійському, арабському, іспанському, руському, українському, непальському, гаїтянському креольському та креольським мовами. | Копії нашої Політики фінансової допомоги, Форми заявки та цього Короткого огляду доступні англійською, арабською, іспанською, російською, українською, непальською, гаїтянською креольською та креольською мовами. | हाम्रो वित्तीय सहायता नीति, आवेदन फारम र यो सारांशको प्रतिलिपिहरू अङ्ग्रेजी, अरबी, स्पेनिश, रूसी, यूक्रेनी, नेपाली, हाइटी क्रियोल र क्रियोलमा उपलब्ध छन्। | Kòpi sou Politik Ed Finansye nou an, Fòm Aplikasyon an, ak Rezime sa a disponib an Angle, Arab, Panyòl, Ri, Ikrenyen, Nepalè, Kreyòl Ayisyen, ak Kreyòl. | وهذا الملخص باللغة الإنجليزية، والعربية، والإسبانية، والروسية، والأوكرانية، والنيبالية، والكريولية الهايتية، والكريولية.

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 COUNTY

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

Primary Phone Number: (____) _____ ☐ Home ☐ Mobile ☐ Work ☐ Other _____

Email Address: _____

Health insurance at time of date of service: _____ ☐ No Insurance ☐ 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 the patient is the intended recipient)	\$ _____	\$ _____
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. 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. Patient: _____
2. _____
3. _____
4. _____
5. _____

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: _____

Return your completed application to: CCF – Financial Assistance Application PO BOX 932553 CLEVELAND OH 44193