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 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 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: _____

Cleveland Clinic

Financial Assistance Program

Dear Patient,

Under the Ohio Hospital Care Assurance Program (HCAP), Cleveland Clinic, 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, Cleveland Clinic provides financial assistance on a sliding scale to patients who live in surrounding counties in Ohio, Florida and Nevada and do not have insurance at family income levels up to four (4) times the Federal Poverty Guidelines.

2012 FEDERAL POVERTY INCOME GUIDELINES*

Family Size	**(HCAP) 2012 Federal Poverty Income Level*	*CC Financial Assistance Program (Family income up to 400% of Federal Poverty Level)*
1	$11,170.00	$44,680.00
2	15,130.00	60,520.00
3	19,090.00	76,360.00
4	23,050.00	92,200.00
5	27,010.00	108,040.00
6	30,970.00	123,880.00
7	34,930.00	139,720.00
8	38,890.00	155,560.00
For each additional family member add $3,960		

If you receive medical services at Cleveland Clinic, 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
6801 Brecksville Road / RK2-3
Independence, OH 44131

PWO 11371 Rev. 2/12

If you are seen by a Cleveland Clinic doctor, the Cleveland Clinic Financial Assistance Program also may provide help with your physician-related expenses.

The Cleveland Clinic Financial Assistance Program may not provide assistance for expenses for your non-Cleveland Clinic 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, Medina 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 live in the State of Ohio or a recognized County in Florida or Nevada.
3. You must be between 101% - 400% of the Federal Poverty Income Guidelines.
4. Family members include individuals listed as your dependents on the most recently filed federal income tax return.

In order to expedite processing your application, please make sure all information is provided. Missing information will result in a denied application.

Cleveland Clinic

Financial Assistance Application Form

Please carefully read 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 or Family Health Center _____
- ❑ Fairview _____
- ❑ Lakewood _____
- ❑ Lutheran _____
- ❑ Hillcrest _____
- ❑ Medina _____
- ❑ Euclid _____
- ❑ Huron _____
- ❑ Marymount _____
- ❑ Cleveland Clinic Florida _____
- ❑ South Pointe _____
- ❑ Lou Ruvo _____

SECTION TWO: PATIENT INFORMATION

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

Name: _____
LAST FIRST MIDDLE INITIAL

Address: _____
NUMBER AND STREET

City: _____ County: _____ State of Residence: _____

Zip Code: _____ Social Security Number: _____ / _____ / _____

Date of Birth: _____ / _____ / _____ Marital Status: ❑ Single ❑ Married ❑ Divorced

Date(s) of Service: _____

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: _____