Cleveland Clinic
Rehabilitation Hospital
In affiliation with Select Medical

Summary of Financial Assistance

Ohio Hospital Care Assurance Program (HCAP). As a participant in the HCAP Program, we offer 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 the Cleveland Clinic Rehabilitation Hospital.

Financial Assistance Offered. If you do not have insurance, we provide financial assistance for 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 Ohio. 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 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:**

- *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 CCRH medical staff or you would benefit from continued medical services from CCRH tor continuity of care, you will be considered on a case by case basis for financial assistance for that specific treatment.

Charges Will Not Exceed Amounts Generally Billed. If you receive financial assistance under our Policy, you will not be charged more for medically necessary care than the amount we generally bill patients having 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.orgifinancialassistance, and (2) in our admissions area. If you call our Central Business Office at 866.284.0235, 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 admission 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 Central Business Office team for evaluation and processing. If you think you may have exceptional or special medical circumstances, a representative can initiate an application for you. If you need any help in applying, please contact our admissions department located at our facilities or call our Central Business Office at 866.284.0235.

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

Las copias de nuestra Polftica de ayuda financiera, el Formulario de solicitud y el presente Resumen estan disponibles en espana.

توفر نسخ من سياسة المساعدة المالية، ونموذج الطلب، وهذا الملخص، باللغات الإنجليزية، والعربية، والإسبانية، والكريو

Return your completed application to: **IP Rehab Central Business Office - Cleveland Clinic**
P.O. Box 932923, Cleveland, OH 44193 (866) 284-0235

Cleveland Clinic
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Financial Assistance Application Form

SECTION ONE: PATIENT INFORMATION

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

Account Number________________________ Date(s) of Service ________________________

Patient Name: ____
LAST FIRST MIDDLE INITIAL

Address: ________________________ City:________________ County: ________________
NUMBER AND STREET

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. ____
6. ____

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: **Cleveland Clinic Rehab CBO**
PO Box 932923, Cleveland, OH 44193-0026 (866) 284-0235