FIRELANDS
Regional Medical Center

Financial Counseling
1111 Hayes Avenue
Sandusky, OH 44870
Telephone 419-557-7879
FinancialCounselors@Firelands.com

Dear Patient,

Thank you for choosing Firelands Regional Medical Center for your healthcare needs.

The information that you provided during your visit with us indicates that you have no insurance or limited coverage. We have several programs that may assist you in paying your bill, whether or not you have insurance. These programs provide free or discounted care depending on ability to pay.

An application is enclosed with a checklist and a guideline explaining the financial assistance services we offer. Please complete the application and return the following items **within 2 weeks of the date you receive this letter.**

- **Completed application front and back signed and dated with attached verifications**

You must provide proof of income **such as: a copy of your W2, payroll stubs from 3 months prior to the date of service with year to date gross income**, Social Security/Disability income, pension income, unemployment, VA benefits, and worker compensation. If you have no means of support, please advise us how you are meeting your daily living needs.

If you prefer, you may scan and email this information, or drop it off at the front desk of Main or South Campus. Please ensure that you have all documentation needed.

We will evaluate your information and you will receive a letter indicating the status of your application.

We are available to answer any questions you may have regarding this process.
Please contact us at 419-557-7879 Monday – Friday from 8a.m. until 4:30 p.m.
You may also email us at FinancialCounselors@Firelands.com.
Appointments are available upon request.

Sincerely,

Patient Financial Counseling

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FINANCIAL ASSISTANCE APPLICATION (turn page over)

PATIENT NAME _____ **DATE OF BIRTH** _____ **DATE** _____

APPLICANT NAME_____
If Applicant is not the patient, answer the following questions as they apply to the patient)

STREET _____ ____**CITY** _____

STATE _____ **ZIP CODE** _____ **PHONE**_____

Accounts	**Dates of Service**	**$Dollar Amount**		
			☐ Inpt.	☐ Outpt. ☐ ER
			☐ Inpt.	☐ Outpt. ☐ ER
			☐ Inpt.	☐ Outpt ☐ ER
			☐ Inpt.	☐ Outpt ☐ ER
			☐ Inpt.	☐ Outpt ☐ ER

1. **Did you have any plan, policy, group or insurance at the time of your hospital service that reimburses for medical expenses (e.g. Christian policy or plan, Worker's Comp, MMO, etc)** ☐ Yes ☐ No
2. **Are you citizen of the United States?** ☐ Yes ☐ No
3. **Were you an active Medicaid recipient at the time of your hospital service or on Disability** ☐ Yes ☐ No
4. **At your time of service were you a legal permanent Ohio Resident?** ☐ Yes ☐ No

Attach to this application any cards you have to verify coverage or a written notice of coverage

*****Deadline to apply for Financial Assistance is 3 years from first notification of bill*****

For HCAP purposes immediate family includes patient, patient's spouse and all the patient's children under 18 (natural and adoptive) who live in the patient's home. If the patient is under age 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 (List Patient also)	**Age**	**Relationship to Patient**	**Income 3 months prior**	**Income 12 months prior**	**Type of Income Verification**

Total family members_____ Total family income _____

****Explain how you are living financially if claiming 0 income**_____
_____

****Proof of Income must accompany this application for the appropriate time period (3 or 12 months prior to hospital service)****
RETURN TO Firelands Regional Medical Center, 1111 Hayes Ave., Sandusky, OH 44870 Attn: Financial Counseling

*****By my signature below, I certify everything I have stated on this application and on attachments is true.*****
If incorrect information is given at the time of application, this determination may be rescinded upon review.

****Signature**_____**Date** _____******

Hospital Use: Approved _____FC _____DATE_____

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FINANCIAL APPLICATION continued….verification checklist

PATIENT NAME : _____

X if you have any of these	INCOME	PLEASE PROVIDE THESE DOCUMENTS TO APPLY
	W2 / TAXES	1040 FORM WITH W2
	PAY STUBS	LAST PAY STUB FOR EACH FAMILY MEMBER WORKING
	SOCIAL SECURITY	SS LETTER SHOWING GROSS AMOUNT
	PENSION / RETIREMENT	DOCUMENT SHOWING GROSS AMOUNT
	VA DISABILITY	DOCUMENT SHOWING GROSS AMOUNT
	UNEMPLOYMENT	DOCUMENT SHOWING GROSS AMOUNT
	SELF EMPLOYMENT	DOCUMENT SHOWING INCOME /BUSINESS EXPENSES
	RENTAL INCOME	DOCUMENT SHOWING GROSS RENTAL INCOME
	CHILD SUPPORT / ALIMONY	DOCUMENT SHOWING GROSS AMOUNT
	OTHER MONIES COMING IN TO HOUSEHOLD	PROVIDE VERIFICATION
	BANK ACCOUNT/S	CURRENT STATEMENT FOR EACH ACCOUNT
***	**RESOURCES**	**RETURN ONLY FOR SECONDARY HARDSHIP REVIEW**
	CASH	AMOUNT
	STOCKS, BONDS, CD , TRUST	DOCUMENT SHOWING VALUE
	IRA / 401K	DOCUMENT SHOWING VALUE
	VEHICLES / CAMPER / BOAT	REGISTRATION OR TITLE
	LOANS / OTHER DEBT /MEDICAL BILLS	DOCUMENT SHOWING AMOUNT OWED
***	**ADDITIONAL FAMILY MEMBERS**	

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2021 Financial Assistance Programs
Effective for services on or after January 13, 2021
For Prior Services Refer to 2020 Guidelines

Hospital Care Assurance Program (HCAP): Firelands Regional Medical Center complies with the State funded Hospital Care Assurance Program as defined in the Ohio Revised Code section 5160-1-01. Firelands Regional Medical Center will provide access to essential care on any basis, and will provide access to essential health services without regard for individual consumers' ability to pay. Patients are eligible for the Hospital Care Assurance Program through a formalized application process.

Financial Assistance Program (FAP) is Firelands Regional Medical Center's program for patients in financial need. Patients are eligible for free or discounted services through a formalized application process.

What are the Financial Assistance Program requirements?
The qualifications for assistance will be determined by an application, based on a percent of current Federal Poverty Guidelines. Income, other earnings, family size and other criteria are needed to process your application. Applications for assistance must be complete, legible, signed and dated by the patient, guarantor or representative. Applications not meeting these conditions will be returned to the applicant or considered denied.

All amounts listed below are income limits based on the Federal Poverty Guidelines which are adjusted annually.

Family Size	**100% or below of** Federal Poverty Guidelines Hospital Care Assurance **100% Free Care (HCAP)**	**101% to 200% of** Federal Poverty Guidelines Financial Assistance Program **100% Free Charity Care (FAP)**	**201% to 302% of** Federal Poverty Guidelines Financial Assistance Program **62% Discounted Care (FAP)**
1	$12,880.00	$12,881.00 to $25,760.00	$25,761.00 to $38,898.00
2	$17,420.00	$17,421.00 to $34,840.00	$34,841.00 to $52,608.00
3	$21,960.00	$21,961.00 to $43,920.00	$43,921.00 to $66,319.00
4	$26,500.00	$26,501.00 to $53,000.00	$53,001.00 to $80,030.00
5	$31,040.00	$31,041.00 to $62,080.00	$62,081.00 to $93,741.00
6	$35,580.00	$35,581.00 to $71,160.00	$71,161.00 to $107,452.00
7	$40,120.00	$40,121.00 to $80,240.00	$80,241.00 to $121,162.00
8	$44,660.00	$44,661.00 to $89,320.00	$89,321.00 to $134,873.00

For families with more than 8 persons, add $4540. for each additional person

How do I apply for the Financial Assistance Programs?
Patients or their designee are asked to complete an application and checklist. Applicants must provide proof of income, such as a copy of your W2, paystubs for the last 3 months with year to date gross income, Social Security/Disability income, pension income, unemployment, VA benefits, or Workers Compensation. If you have no means of support, you will need to advise how you are meeting your daily living needs with a brief statement. The Financial Department will evaluate your information and send you a letter verifying your eligibility. Please return all verifications to Firelands Regional Medical Center, 1111 Hayes Ave., Sandusky, OH 44870, Attention: Financial Counseling. You may also email to: FinancialCounselors@Firelands.com.
Please feel free to contact us at 419-557-7879 for further assistance.