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, call for an appointment, or simply stop in to see a Financial Counselor. Please ensure that you have all documentation needed to avoid rescheduling.

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 8:00 a.m. until 4:30 p.m.
You may also email us at FinancialCounselors@Firelands.com.
Appointments are available upon request.

Sincerely,

Patient Financial Counseling

FIRELANDS Regional Medical Center

HCAP

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

Did you have Health Insurance at the time of your hospital service? ☐ Yes ☐ No

Were you an active recipient of Disability Assistance at the time of your hospital service? ☐ Yes ☐ No

Were you an active Medicaid recipient at the time of your hospital service? ☐ Yes ☐ No

Were you an Ohio Resident at the time of your hospital service? ☐ Yes ☐ No

If you answered Yes to any question, please attach a copy of your Insurance, Medicaid, or DA card to this application.

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

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

Hospital Use Only:

Approved _____ Denied _____ Reason: _____

Financial Counselor: _____ Date: _____ Review:_____

FIRELANDS Regional Medical Center

HCAP

FINANCIAL ASSISTANCE APPLICATION *(continued)*
VERIFICATION CHECKLIST

PATIENT NAME: _____

X if you have any of these	INCOME		Please Provide This VERIFICATION
	W2 / TAXES		1040 FORM WITH W2
	PAYSTUBS		LAST PAYSTUB 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 AND BUSINESS EXPENSES
	RENTAL INCOME		DOCUMENT SHOWING GROSS RENTAL INCOME
	CHILD SUPPORT / ALIMONY		DOCUMENT SHOWING GROSS AMOUNT
	OTHER INCOME		PROVIDE VERIFICATION
	RESOURCES	**VALUE**	**PLEASE PROVIDE THIS VERIFICATION**
	CASH		AMOUNT
	BANK ACCOUNTS		CURRENT STATEMENT FOR EACH ACCOUNT
	STOCKS, BONDS, CD, TRUST		DOCUMENT SHOWING VALUE
	IRA / 401K		DOCUMENT SHOWING VALUE
	VEHICLES / CAMPER / BOAT		REGISTRATION OR TITLE
	TOTAL		
	LOANS / DEBT / MEDICAL BILL		DOCUMENT SHOWING AMOUNT OWED
ADJ. TOTAL			**REVIEW /**

FIRELANDS
Regional Medical Center

2018 Financial Assistance Programs
Effective for services on or after January 13, 2018
For Prior Services Refer to 2017 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 (HCAP) Hospital Care Assurance **100% Free Care**	101% to 200% of Federal Poverty Guidelines (FAP) Financial Assistance Program **100% Free Charity Care**	201% to 300% of Federal Poverty Guidelines (FAP) Financial Assistance Program **60% Discounted Care**
1	$12,140.00	$12,141.00 to $24,280.00	$24,281.00 to $36,420.00
2	$16,460.00	$16,461.00 to $32,920.00	$32,921.00 to $49,380.00
3	$20,780.00	$20,781.00 to $41,560.00	$41,561.00 to $62,340.00
4	$25,100.00	$25,101.00 to $50,200.00	$50,201.00 to $75,300.00
5	$29,420.00	$29,421.00 to $58,840.00	$58,481.00 to $88,260.00
6	$33,740.00	$33,741.00 to $67,480.00	$67,481.00 to $101,220.00
7	$38,060.00	$38,061.00 to $76,120.00	$76,121.00 to $114,180.00
8	$42,380.00	$42,381.00 to $84,760.00	$84,761.00 to $127,140.00

For families with more than 8 persons, add $4320 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.