FIRELANDSHEALTH
Firelands Regional Medical Center
Financial Counseling
1111 Hayes Avenue
Sandusky, OH 44870
FinancialCounselors@Firelands.com
FRMC: 419-557-7879
Firelands.com

FIRELANDSHEALTH
Firelands Physician Group
Financial Counseling
1111 Hayes Avenue
Sandusky, OH 44870
FirelandsPhysicianGroupBilling@Firelands.com
FPG: 419-557-5530
Firelandsphysiciangroup.com

Dear Patient,

Thank you for choosing Firelands Health 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 guideline explaining the financial assistance services we offer. **This application is for Firelands hospital bills and Firelands Physician Group bills**. Please complete the application and return the following items **within 2 weeks of the date you receive this letter.**

Completed application signed and dated with attached income 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, Worker Compensation and other sources of income. 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 one of our Drop Boxes at Main or South Campus lobby. Please ensure that you have all the documentation needed.

We will evaluate your information and you will receive a letter indicating the status of your application. **Applications expire 3 months after last date of service and you must reapply for future service dates**.

We are available to answer any questions you may have regarding this process.
Please contact us at: *FinancialCounselors@Firelands.com* or 419-557-7879
***FirelandsPhysicianGroupBilling@Firelands.com* or 419-557-5530**

Monday – Friday from 8a.m. until 4:30 p.m.
***Appointments are available upon request*.**

Sincerely,

Patient Financial Counseling

FIRELANDSHEALTH
Firelands Regional Medical Center

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FIRELANDSHEALTH
Firelands Physician Group

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. or Dr.	☐ ER
_____		☐ Inpt. ☐ Outpt. or Dr.	☐ ER
_____		☐ Inpt. ☐ Outpt. or Dr.	☐ ER
_____		☐ Inpt. ☐ Outpt. or Dr.	☐ ER
_____		☐ Inpt. ☐ Outpt. or Dr.	☐ ER

At service date did you have any plan, group, or insurance that reimburses or pays medical expenses? ☐ Yes ☐ No
Ins or Plan Name_____ ***Policy#***_____ ***Attach copy of Card***

1. **Are you a citizen of the United States?** ☐ Yes ☐ No **Are you an Ohio Resident?** ☐ Yes ☐ No
2. **Were you an active Medicaid recipient at the time of your hospital service or on Disability** ☐ Yes ☐ No

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

Immediate family defined as 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)	Birthdate	Relation to Patient	Name	Birthdate	Relation to Patient
1.			6.		
2.			7.		
3.			8.		
4.			*Hospital Use Only*	*3mo.*	*12 mo.*
5.					

Total family members_____

Total Income

****If zero income explain how you are living**_____

**** Income verification must be attached****: *paystubs showing 3 mos. and year to date gross income prior to service date: Pension, Social Security, Disability, Unemployment,Workers Comp, VA, Self- employment, Rentals, Alimony, Child Support, 401/IRA withdraws,*

FinancialCounselors@Firelands.com **or 419-557-7879, *FirelandsPhysicianGroupBilling@Firelands.com* or 419-557-5530**
MAIL: Firelands Regional Medical Center, 1111 Hayes Ave., Sandusky, OH 44870, Attn: Financial Counseling
DROP OFF: Drop box at Main and South Campus in the lobby
Appointments Available Upon Request.

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

Hospital Use: *Approved* *Denied* *Reason* _____*FC* _____*Date*_____

FIRELANDSHEALTH
Firelands Regional Medical Center

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FIRELANDSHEALTH
Firelands Physician Group

2024 Financial Assistance Programs
Effective for services on or after January 17, 2024
For Prior Services Refer to 2023 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 and Firelands Physician Group program for patients in financial need. Patients are eligible for free or discounted services through a formalized application process. **This program also extends to below poverty line if patient is ineligible for HCAP**.

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	$15,060.00	$15,061.00 to $30,120.00	$30,121.00 to $45,481.20
2	$20,440.00	$20,441.00 to $40,880.00	$40,881.00 to $61,728.80
3	$25,820.00	$25,821.00 to $51,640.00	$51,641.00 to $77,976.40
4	$31,200.00	$31,201.00 to $62,400.00	$62,401.00 to $94,224.00
5	$36,580.00	$36,581.00 to $73,160.00	$73,161.00 to $110,471.60
6	$41,960.00	$41,961.00 to $83,920.00	$83,921.00 to $126,719.20
7	$47,340.00	$47,341.00 to $94,680.00	$94,681.00 to $142,966.80
8	$52,720.00	$52,721.00 to $105,440.00	$105,441.00 to $159,214.40

For families with more than 8 persons, add $5380. for each additional person

How do I apply for the Financial Assistance Programs?

Patients or their designee are asked to complete an application. 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, pension, Unemployment, VA benefits, Workers Compensation and other income. 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. You may be asked to apply for Medicaid prior to approval if your income denotes eligibility.

Please return all verifications to Firelands Regional Medical Center, 1111 Hayes Ave., Sandusky, OH 44870, Financial Counseling. You may also email to ***FinancialCounselors@Firelands.com.*** 419-557-7879 or ***FirelandsPhysicianGroupBilling@Firelands.com*** or 419-557-5530.