FIRELANDS
Regional Medical Center

Financial Counseling
1111 Hayes Avenue
Sandusky, OH 44870
Telephone 419-557-7879
FinancialCounselors@Firelands.com
www.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 you have insurance or not. These programs provide free or discounted care depending on ability to pay.

Enclosed is an application and a letter explaining the financial assistance services we offer. Please complete the application and return the following items:

- Completed application
- Proof of income

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.

Return the requested information to us in the postage paid envelope provided. You may also scan and email this information to FinancialCounselors@Firelands.com.

The application and proof of income must be received within **2 weeks of the date you receive this letter.**

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 a.m. until 5 p.m. or by email at FinancialCounselors@Firelands.com

Sincerely,

Patient Financial Counseling

FIRELANDS
Regional Medical Center

HCAP

APPLICATION FOR HOSPITAL CARE ASSURANCE PROGRAM (HCAP)

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

APPLICANT NAME, IF NOT PATIENT: _____
(If applicant is not the patient, answer the following questions as they apply to the patient)

STREET: _____ CITY: _____

STATE: _____ ZIP CODE: _____

	From	To	ACCT#	$ DOLLAR AMT	
Date(s) of Service:	_____	_____	_____	_____	☐ Inpatient ☐ Outpatient ☐ ER
	_____	_____	_____	_____	☐ Inpatient ☐ Outpatient ☐ ER
	_____	_____	_____	_____	☐ Inpatient ☐ Outpatient ☐ 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 ____

If yes, Medicaid Recipient ID number: _____

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. 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 and 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	Age	Relationship to Patient	Income 3 months prior to hospital service *	Income 12 months prior to service *	Type of Income Verification attached **
(Patient)		(self)			

Total persons in family: _____ Total family income: _____

*Income verification must accompany this application. If you reported $0 income you must attach a brief explanation of how you are living financially: _____

**Income verification must be attached and may include: PAY STUBS, W-2'S OR OTHER DOCUMENTS CONTAINING INCOME INFORMATION FOR THE APPROPRIATE TIME PERIOD (3 OR 12 MONTHS PRIOR TO HOSPITAL SERVICE).

Mail to: Firelands Regional Medical Center, 1111 Hayes Avenue, Sandusky, OH 44870. Attn: Financial Counseling.

By my signature below, I certify everything I have stated on this application and on attachments is true.

Applicant Name: _____ Date: _____

Hospital Use Only

Approved _____ Denied _____ Reason: _____

Financial Counselor: _____ Date: _____ Reviewed By: _____

FIRELANDS Regional Medical Center

HCAP

APPLICATION FOR HOSPITAL CARE ASSURANCE PROGRAM (HCAP)

ADDITIONAL ACCOUNTS			
DATES OF SERVICE FROM TO	**Account#**	**Amount**	**Patient Type**

FIRELANDS
Regional Medical Center

HCAP

APPLICATION FOR HOSPITAL CARE ASSURANCE PROGRAM (HCAP)

ADDITIONAL ACCOUNTS					
DATES OF SERVICE	**FROM**	**TO**	**Account#**	**Amount**	**Patient Type**

FIRELANDS
Regional Medical Center

2014 Financial Assistance Programs
Effective for services on or after January 22, 2014
For Prior Services Refer to 2013 guidelines

Hospital Care Assurance Program: Firelands Regional Medical Center complies with the State funded Hospital Care Assurance Program as defined in the Ohio Revised Code section 5112.17. 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.

Hospital Financial Assistance Discount Program 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, and family size are used to calculate the need for assistance. 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.

****Financial Assistance Discount Program effective beginning 06/01/2005****
2014 Discounts effective for Dates of Service on or after January 22, 2014**

Family Size	100% or below of Federal Poverty Guidelines, **Hospital Care Assurance Program**	101% to 200% of Federal Poverty Guidelines 100% **Free Care Discount**	201% to 300% of Federal Poverty Guidelines **25% Discount**
1	$11,670.00	$11,671.00 to $23,340.00	$23,341.00 to $35,010.00
2	$15,730.00	$15,731.00 to $31,460.00	$31,461.00 to $47,190.00
3	$19,790.00	$19,791.00 to $39,580.00	$39,581.00 to $59,370.00
4	$23,850.00	$23,851.00 to $47,700.00	$47,701.00 to $71,550.00
5	$27,910.00	$27,911.00 to $55,820.00	$55,821.00 to $83,730.00
6	$31,970.00	$31,971.00 to $63,940.00	$63,941.00 to $95,910.00
7	$36,030.00	$36,031.00 to $72,060.00	$72,061.00 to $108,090.00
8	$40,090.00	$40,091.00 to $80,180.00	$80,181.00 to $120,270.00

For families with more than 8 persons, add $4,060 for each additional person.

How do I apply for the Hospital Financial Assistance Program?

Patients or their designee are asked to complete an application. Applicants must provide proof of income, such as a copy of your W2, payroll stubs for the last 3 months with year to date gross income, Social Security/Disability income, pension income, unemployment, VA benefits, and workers compensation. If you have no means of support, you will need to advise how you are meeting your daily living needs. The Hospital Financial Counselor will evaluate your information and you will receive a letter indicating if your application has been approved. Please return proof of income information to Firelands Regional Medical Center, 1111 Hayes Ave., Sandusky, OH 44870, Attention: Financial Counseling. You may also scan and email your proof of income information to FinancialCounselors@Firelands.com

Please feel free to contact us at 419-557-7879 for further assistance.