**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



PS-1154 Rev. 8/17

**FIRELANDS** Regional Medical Center

# 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

# 2017 Financial Assistance Programs
# Effective for services on or after January 24, 2017
# For Prior Services Refer to 2016 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** | $12,060.00 | $12,061.00 to $24,120.00 | $24,121.00 to $36,180.00 |
| **2** | $16,240.00 | $16,241.00 to $32,480.00 | $32,481.00 to $48,720.00 |
| **3** | $20,420.00 | $20,421.00 to $40,840.00 | $40,841.00 to $61,260.00 |
| **4** | $24,600.00 | $24,601.00 to $49,200.00 | $49,201.00 to $73,800.00 |
| **5** | $28,780.00 | $28,781.00 to $57,560.00 | $57,561.00 to $86,340.00 |
| **6** | $32,960.00 | $32,961.00 to $65,920.00 | $65,921.00 to $98,880.00 |
| **7** | $37,140.00 | $37,141.00 to $74,280.00 | $74,281.00 to $111,420.00 |
| **8** | $41,320.00 | $41,321.00 to $82,640.00 | $82,641.00 to $123,960.00 |

For families with more than 8 persons, add $4180 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.