MetroHealth

Financial Assistance Program Eligibility

Applicant's Name:
Medical Record No.:
Effective From: **To:**

This form indicates you are eligible for a Financial Assistance Program of The MetroHealth System ("MetroHealth"). Please be aware of the effective dates. By accepting this Financial Assistance Program, you confirm that you understand and agree to the following terms and conditions:

- This Financial Assistance Program is NOT insurance coverage.

- Should MetroHealth discover you are eligible for a third-party resource related to this treatment, your Financial Assistance Program will be immediately revoked. Full charges reapplied to your account until you satisfy the balance out of the third-party recovery.

- MetroHealth may review or cancel the Financial Assistance Program and adjust past claims if it determines that the Financial Assistance Program was based on incorrect information, either financial or demographic. MetroHealth also reserves the right to amend or cancel this Financial Assistance Program at any time upon notice to you.

- You must comply with the application process for any program that might make payment for services or the discount you have been assigned through this Financial Assistance Program could be retroactively revoked.

- The Financial Assistance Program helps with MOST MEDICALLY NECESSARY SERVICES and ONLY covers services provided by MetroHealth. For example, it DOES NOT cover Bariatric Surgery, dental services, and pharmacy services. Dental services and pharmacy services may be available through separate programs.

- Applicants with a household income up to 100% of the Federal Poverty Limit who are admitted to the hospital must be re-interviewed immediately before or after the admission.

- You understand that you are eligible for the Financial Assistance Program and are responsible for ___% of charges for services covered under this Financial Assistance Program.

We are here to assist you. Please contact the Eligibility Call Center at 216-957-2325 (select Option 1) with any questions.

Financial Counselor Signature: _____ Date: _____