Cleveland Clinic Children's

When your child needs quality care right away...

Cleveland Clinic Children's is there. For your convenience, our mobile pediatric unit visits your child's school regularly so you don't need to interrupt your schedule to go to the doctor's office.

Our pediatric provider services include:

- Physical exams (general, sports, pre-employment)
- Diagnosis and treatment for minor illnesses and injuries
- Immunizations as needed (tetanus, MMR, etc.)
- Prescription medication
- And more

And our providers can work with your child's primary healthcare provider, if necessary.

All you need to do...

If your child is currently enrolled in the school district, simply complete the School-Based Health Center enrollment packet. This can be done by visiting **clevelandclinicchildrens.org/school**. Enrollment is free and required for care. It can be discontinued at any time.

For more information regarding enrollment, payment, FAQs, and a complete list of services, go to clevelandclinicchildrens.org/school, call 216.442.7242 or email SBHCteam@ccf.org.

For specific questions regarding your school district, please contact your school nurse.

We look forward to caring for your child in a comfortable and safe environment in your neighborhood.

Cleveland Clinic Community Care | Primary Care Pediatrics | 6000 West Creek Drive / RC20
Independence, Ohio 44131 | 216.442.7242

Cleveland Clinic

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Cleveland Clinic Hospital and/or its affiliated facilities (each and all of them referred to as "CC" in this form).

Consent to Health Care Services: I am requesting that health care services be provided to me (or my minor child or the patient named below) at CC. I voluntarily consent to all medical treatment and health care-related services that the caregivers at CC consider to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my CC caregiver. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

I understand that CC may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

Financial Responsibility:

a. Subject to applicable law and the terms and conditions of any applicable contract between CC and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I agree to be financially responsible and obligated to pay CC for any balance not paid under the "Assignment of Benefits/ Third Party Payers" paragraph below.

Or, b. Subject to applicable law and the Cleveland Clinic Health System Financial Assistance Policy, and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay CC for the patient balances due.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to CC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding CC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by CC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

Patient Rights and Responsibilities: I have received a copy of the Cleveland Clinic Health System Patient Rights and Responsibilities brochure or the Cleveland Clinic Health System Welcome Guide.

Uses and Disclosures of Health Information: I have received Cleveland Clinic Health System's Notice of Privacy Practices. The Notice of Privacy Practices explains how Cleveland Clinic Health System may use and disclose confidential health information that identifies me (or the below-named patient). I consent to let Cleveland Clinic Health System use and disclose health information about me (or the below-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the below-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by CC, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent CC or provide assistance to CC for the purposes of securing payment from all parties who are potentially liable for payment for my (or the below named patient's) health care, including for substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that CC has already relied on my consent.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to CC on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from CC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who

may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from CC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I hereby consent and grant to CC the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by CC. I understand that I have the right to request cessation of recording or filming at any time. I agree to release and forever discharge CC, its agents, officers and employees from any and all claims arising out of or in connection with the use of these images and/or recordings including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

Teaching Facility/Clinical Studies: CC is a teaching facility. Doctors and others in training may be involved in my (or the below-named patient's) health care. Many CC patients participate in clinical studies. I can ask my (or the below-named patient's) doctor questions about having health professionals in training involved in the care and about participating in clinical studies, and I can explain any views I have. Clinical studies at CC go through a special process required by law that reviews patient welfare and privacy. CC patients usually consent in writing to participate in clinical studies. Sometimes family members or other surrogates are asked for consent when patients are not mentally able to give their own consent. Patients are encouraged to discuss how they feel about being research participants with family members so they will know the patients' wishes if asked.

Valuables/Limitation of Liability: I understand that I should not bring valuables (cell phone, electronic devices, medical equipment, jewelry, money, irreplaceable documents, etc.) with me to CC. If I choose to bring valuables to CC, I AGREE THAT CC SHALL NOT BE RESPONSIBLE FOR VALUABLES UNLESS THEY ARE DEPOSITED IN THE ADMINISTRATIVE SERVICE CENTER LOCATED IN THE HOSPITAL ADMITTING DEPARTMENT. If I do deposit valuables, CC's LIABILITY IS LIMITED to loss or damage caused by willful or wanton negligence. If I do not deposit valuables in the administrative service center, CC is not responsible for them, even if I (or the patient named below) give(s) them to other CC personnel. I also understand that CC may tell me not to use a valuable at any time. Items in CC's Lost and Found are given to charity after 30 days.

By signing below, I am indicating that I have reviewed and acknowledge and consent to the terms described above.

In Person Consent

Signature of Patient or Responsible Party ***Date/Time***

X _____ _____

Printed Name of Patient (or Responsible Party if not the Patient) ***Responsible Party's Relationship to Patient***

_____ _____

Phone Number(s)

Home _____ **Cellular** _____

-OR-

Telephone Consent

Printed Name of Individual Providing Telephone Consent ***Date/Time***

_____ _____

Printed Name of Patient (or Responsible Party if not the Patient) ***Responsible Party's Relationship to Patient***

_____ _____

Phone Number(s)

Home _____ **Cellular** _____

Cleveland Clinic Children's

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

School-Based Health Program, Community Pediatrics
Cleveland Clinic Children's
6000 West Creek Drive
Independence, Ohio 44131

Telephone: 216-442-7242

Patient: _____ Last 4 Digits of Patient's SSN: _____

Clinic #: _____ Date of Birth: _____/_____/_____

Telephone #: _____ Current Address: _____

City: _____ State: _____ Zip: _____

For the purposes of this form, "my," and "I" mean the patient listed above whose record is maintained by Cleveland Clinic.

I hereby authorize Cleveland clinic to release any and all health information that is contained in my patient records to my current school for treatment and as otherwise needed for my safety and education at the sole discretion of Cleveland Clinic. **I understand and acknowledge that this may include health information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and /or alcohol/drug abuse. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

This authorization form will automatically expire when Cleveland Clinic is no longer providing school-based health care services to the students of my current school, when I am no longer a student of my current school, or when I revoke this authorization, whichever occurs first. I may revoke this authorization at any time, through written notice sent to: Administrator, Community Pediatrics, Cleveland Clinic Children's, 6000 West Creek Drive, Independence, Ohio 44131. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected. The recipient of my health information may be charged for the service of releasing medical information.

If Authorization is not complete, signed, and dated, it may be returned and result in my information not being released until completed

_____ _____/_____/_____

Signature of Patient/Patient's Personal Representative** Date Signed

_____ _____

Printed Name Relationship, if not Patient

* Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

** If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative must accompany the request (e.g., court-appointed guardian of the person, durable power of attorney for health care). Exception: Parent signing for a patient under the age of eighteen.

Section A: Patient Demographics

Student Name:			
Date of Birth: _____/_____/_____ Month Date Year		Sex: ☐ Female ☐ Male	Social Security # :
Address:			City:
State:	Zip Code:	Home Phone # :	Cell Phone #:
Preferred Language:		Do you identify as Hispanic? ☐ Yes ☐ No	
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Multiracial/Multicultural ☐ Native Hawaiian/Pacific Islander ☐ Caucasian ☐ African American ☐ Declined			
Name of Primary Care Physician:			

Section B: YES, I have Medical Insurance

Insurance Information (Guarantor)

Insurance Holder's Name as it appears on the insurance card:		
Date of Birth of Insurance Holder: _____/_____/_____ Month Date Year		Social Security # of Insurance Holder :
Insurance Holder's Employer and Address:		
Insurance plan name:	Subscriber ID:	Group Name/Number:
Insurance Company Address:		

Section C: NO, I do not have Medical Insurance

A Financial Counselor will be in contact to provide assistance in your child's care, please provide the following information:

Name:_____

Phone #:_____

Section D: Emergency Contact Information

Name:			
Address:			
City:	State:	Zip Code:	Relationship to patient:
Home Phone # :	Cell Phone #:		Work Phone # :

Cleveland Clinic Children's

School-Based Health Clinic History Form

STUDENT NAME _____ **DATE OF BIRTH** _____

(Please check ✓ all that apply)

ALLERGIES	
☐ YES: Please list below ☐ Food: _____ ☐ Medications: _____ ☐ Insects: _____ ☐ Seasonal: _____ ☐ Animals: _____	☐ NO KNOWN ALLERGIES

PAST MEDICAL HISTORY	
☐ Allergies ☐ Asthma ☐ Developmental ☐ Diabetes ☐ Ear Infections ☐ Gastrointestinal	☐ Heart Disease ☐ Neurological ☐ Behavioral: Please list _____ ☐ Other: Please list _____

CURRENT MEDICATIONS

Name of Medication	Dose	Amount Taken	Times per day

PREFERRED RETAIL PHARMACY

Name	Address	Phone Number

(Please check ✓ all that apply)

FAMILY HISTORY	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	*Other:* Please list
Alcohol/Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer-Type?	☐	☐	☐	☐	☐	☐	☐	☐	
Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	
COPD	☐	☐	☐	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	☐	☐	☐	
Developmental Problems	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐	
Gastrointestinal	☐	☐	☐	☐	☐	☐	☐	☐	
Heart	☐	☐	☐	☐	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐	☐	
Psychiatric	☐	☐	☐	☐	☐	☐	☐	☐	
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	
Thyroid	☐	☐	☐	☐	☐	☐	☐	☐	

PARENT/LEGAL GUARDIAN SIGNATURE
(Student can sign if student over age of 18) _____ **DATE** _____

Cleveland Clinic Children's

School-Based Health Center
Student Parental/Court-Appointed Guardian Notice

HIGHLIGHTED AREAS MUST BE COMPLETED FOR SCHEDULING AND REGISTRATION

Please read carefully and complete the following statement acknowledging that your son/daughter/ward may receive services at the Cleveland Clinic Children's School-Based Health Center (CCCSBHC).

Student Name:												**Birth Date:**		
School District:														
School:														
Grade:	**Pre K**	**K**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

I acknowledge that my son/daughter/ward named above may receive the following services at the CCCSBHC:

- Comprehensive Health Inquiry
- Physical Examinations (general, sports, pre-employment)
- Diagnosis and treatment for minor illnesses and injuries
- Screening for select health problems (vision screening, hypertension, etc.)
- Care of certain chronic conditions such as asthma and seizure disorders
- Immunizations as needed (tetanus, measles/mumps, rubella, etc.)
- Individual health and wellness education services
- Routine Lab Tests
- Prescription Medications
- Care for common pediatric/adolescent physical concerns (weight, acne, menstrual problems, etc.)
- Pregnancy Testing
- Birth Control Management
- Diagnosis and treatment of sexually transmitted diseases
- Mental Health Assessments
- Follow-up care as needed

Financial Responsibility: If you have insurance, Cleveland Clinic will bill your insurance company. Any co-pays will be billed. If you are uninsured, a Cleveland Clinic financial counselor will be contacting you to explore possible assistance options.

After Visit Summary: If your child/ward receives services in the CCCSBHC, you/your child will receive an After Visit Summary in a sealed envelope.

Prescriptions: All prescriptions will be electronically prescribed and sent to your preferred pharmacy identified in the School-Based Health Center History Form. Controlled prescriptions will need to be picked up directly from the CCCSBHC mobile unit or the nearest designated Cleveland Clinic Children's physician office.

I certify that I have read this notice and understand its contents.

Signature of Parent/Court-Appointed Guardian: _____ **Dated Signed** _____
(Student can sign if student over age of 18)

Relationship to Student: _____

Cleveland Clinic Children's

Pre-visit Questionnaire

You have enrolled your child in the School Based Health Care Program. To better serve your child we are asking you to answer the following questions and return to your child's school. This information is valuable in keeping your child healthy and learning to the best of their ability.

Patient Information

Child's Name:	
Child's Date of Birth:	
Home Address:	

Guardian Information

Primary Guardian's Name:	
Guardian Relationship to Child:	
Phone Number:	
Best time to call:	

1. **Who is your child's Primary Care Provider (PCP)?**
   - ☐ **No/PCP**
   - ☐ **Yes/PCP – Name** _____
     Location _____

2. **Has your child had a well visit in the last year?**
   Date _____ / _____ / _____ **If greater than 1 year may we schedule an appointment?**
   ☐ **Yes** ☐ **No**

3. **Has your child visited the emergency room in the last 6 months?**
   ☐ **Yes** ☐ **No**

4. **Does your child have any of the following medical conditions: Asthma, Diabetes, Sickle Cell, ADHD, Anxiety, Depression, Self-harm or any other behavior concerns? Is he/she overweight or underweight?**
   ☐ **Yes** ☐ **No**
   a. If yes, which condition?
   _____
   b. If yes, is your child being seen by a provider? ☐ **Yes** ☐ **No**
   If yes, who? _____

5. **Does your child take any daily medications?**
   ☐ **Yes** ☐ **No**
   If yes, list medications:
   _____
   Is a refill needed? ☐ **Yes** ☐ **No**
   If yes, what Prescription(s)
   _____

Pre-visit Questionnaire

6. Does your child have any other health conditions we should be aware of?
   ☐ Yes ☐ No
   If yes, which condition(s)?
   _____

7. How many days has your child missed school in the last 2 months due to illness, medication or other reason?
   ☐ None ☐ 1-2 days ☐ 3-4 days ☐ >5 days Reason:
   _____

8. How many days of work have you (parent/guardian) missed in last 2 months due to your child's illness, medication or other reason?
   ☐ None ☐ 1-2 days ☐ 3-4 days ☐ >5 days Reason:
   _____

9. Does your child have trouble learning?
   ☐ Yes ☐ No
10. Does he or she have an IEP or 504 plan at school?
    ☐ Yes ☐ No
11. Do you think your child is being bullied at school?
    ☐ Yes ☐ No
12. Does your child have a dentist?
    ☐ Yes ☐ No
    If yes, when was the child's most recent dental appointment?
    _____
13. If your child needs vaccinations at the time of his or her visit, may we complete the needed vaccinations?
    ☐ Yes ☐ No
    OK for Influenza vaccine? ☐ Yes ☐ No
    Ok for HPV vaccine? ☐ Yes ☐ No

Thank you for taking the time to answer these questions. We appreciate your input regarding your child's health and well-being. We will make every effort to help your child have a healthy and successful school year.

Cleveland Clinic

Financial Assistance Application Form

SECTION ONE: PATIENT INFORMATION

Print your full name, your address at the time you received medical service and other information noted in this section.

Account Number _____ Date(s) of Service _____

Patient Name: _____
LAST FIRST MIDDLE INITIAL

Address: _____ City: _____ County: _____
NUMBER AND STREET

State of Residence: _____ Zip Code: _____ Date of Birth: ____/____/____ Marital Status: ❑ Single ❑ Married ❑ Divorced

Primary Phone Number: (_____) _____ ❑ Home ❑ Mobile ❑ Work ❑ Other _____

Email Address: _____

Health insurance at time of date of service: ❑ No Insurance ❑ Medicare ❑ Medicaid ❑ Other _____

SECTION TWO: FAMILY INCOME

Provide income for yourself, your spouse and all other family members (if applicable).

Income Source	Total for 3 Months Prior to Service	Total for 12 Months Prior to Service
Wages/Self Employment	$	$
Social Security	$	$
Pension, Dividends, Interest, Rental Income	$	$
Unemployment, Workers' Compensation	$	$
Child Support (only if the patient is the intended recipient)	$	$
Other	$	$

SECTION THREE: FAMILY INFORMATION AND INCOME

List all family members in your household and their date of birth.

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 or 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 of family members, including patient — Date of Birth — Relationship to Patient

1. Patient: _____
2. _____
3. _____
4. _____
5. _____
6. _____

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

Responsible Party Signature: x _____ Date: _____

Return your completed application to: **Patients First Support Services – Cleveland Clinic**
6801 Brecksville Rd., RK2-3, Independence, OH 44131-9980

Cleveland Clinic

Summary of Financial Assistance

Ohio Hospital Care Assurance Program (HCAP). As a participant in the HCAP Program, we offer emergency and other medically necessary services in our hospitals free of charge if you are a resident of Ohio and either (1) you are currently an eligible recipient of the General Assistance or the Disability Assistance Programs or (2) your income is at or below 100% of the Federal Poverty Guidelines (the FPG).

The following is a summary of financial assistance available at all Cleveland Clinic facilities including its hospitals and family health centers. This summary is not applicable to Cleveland Clinic Rehabilitation and Ashtabula County Medical Center facilities which have their own financial assistance policies.

Financial Assistance Offered. If you do not have insurance, we provide financial assistance for emergency and other medically necessary care as a discount from our normal charges if your family income does not exceed four times the FPG and you are a resident of the state in which you are seeking care (Ohio, Florida or Nevada). If you are a Florida resident, you must reside in Broward County and be seeking emergency care services inside the hospital. All applicants will be screened for Medicaid coverage and must cooperate with the Medicaid representatives to be considered for financial assistance. If you are eligible for financial assistance under our Policy, you will receive free or discounted assistance according to the following income criteria:

- If your annual family income is up to 250% of the FPG, you will receive free care,
- If your annual family income is between 251% and 400% of the FPG, you will receive care discounted to the amount we generally bill insured patients for such services.

Even if you have insurance, as long as you meet our income criteria, you will be eligible for financial assistance if: your insurance does not provide coverage for the medically necessary services you are seeking or you have exhausted your lifetime maximum insurance benefits.

Additional Ways to Qualify. If you do not meet the income criteria above, regardless of your insurance status or state of residence, you will be considered on a case-by-case basis for financial assistance under the following circumstances:

- *Catastrophic Balance.* If you have a balance due to Cleveland Clinic of greater than 15% of your annual family income, you will be considered for financial assistance.
- *Exceptional Circumstances.* If you have an extreme personal or financial hardship, you may contact us to be considered for financial assistance.
- *Special Medical Circumstances.* If you are seeking treatment that can only be provided by CCHS medical staff or you would benefit from continued medical services from CCHS for continuity of care, you will be considered on a case-by-case basis for financial assistance for that specific treatment. If you are seeking treatment in Florida, you must be an existing patient of a CC Florida physician.

Maternity Care. If you are pregnant and your insurance does not provide maternity benefits, you will be eligible for financial assistance under our Policy, as long as you meet our income criteria, are an Ohio resident and agree to work with us to determine if you are eligible for maternity benefits under a governmental program.

Charges Will Not Exceed Amounts Generally Billed. If you receive financial assistance under our Policy, you will not be charged more for emergency or other medically necessary care than the amount we generally bill patients having commercial insurance or Medicare coverage.

How to Obtain Copies of Our Policy and Application. You may obtain a copy of our Policy and the Financial Assistance application form: (1) on the Cleveland Clinic's website at www.ccf.org/financialassistance, and (2) in our admissions areas, in our emergency departments, or in any of our patient financial advocate's offices. If you call Patients First Support Services at 866.621.6385 or ask a patient financial advocate, we will mail you a copy of our Financial Assistance Policy, plain language summary and application form free of charge.

How to Apply and Obtain Assistance. You may apply at any point in the scheduling or billing process by completing and submitting an application and providing income information. Any Financial Assistance Application whether completed in person, online, delivered or mailed in, will be forwarded to the Patients First Support Services team for evaluation and processing. If you think you may have catastrophic, exceptional or special medical circumstances, a patient financial advocate or Patients First Support Services representative can initiate an application for you. If you need any help in applying, please contact our patient financial advocates located at our facilities or call Patients First Support Services at 866.621.6385.

Copies of our Financial Assistance Policy, Application Form, and this Summary are available in English, Arabic and Spanish.

Las copias de nuestra Política de ayuda financiera, el Formulario de solicitud y el presente Resumen están disponibles en español.

تتوفر نسخ من سياسة المساعدة المالية ونموذج الطلب وهذا الملخص باللغة العربية.

Return your completed application to: **Patients First Support Services – Cleveland Clinic**
6801 Brecksville Rd., RK2-3, Independence, OH 44131-9980