CONFIDENTIAL FINANCIAL STATEMENT AND FINANCIAL ASSISTANCE APPLICATION

Patient Name:

Account Number(s):

Date of Service(s):

Responsible Party*		**Spouse or Domestic Partner**	
Name	______________________	Name	______________________
Address:	______________________	Address:	______________________
______________________		______________________	
Phone:	______________________	Phone:	______________________
SSN/TIN:	______________________	SSN/TIN:	______________________
Employer:	______________________	Employer:	______________________

Marital Status (circle one):

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Unmarried ☐ Partnered

Family Information:

Please list all persons living with you plus any children 21 or under, whether or not they live with you.

Name:	**Age:**	**Relationship to you:**

Please complete other side.

Monthly Household Income

Gross monthly income from wages $ ______________________

Social Security $ ______________________

Unemployment Compensation $ ______________________

Child Support/Alimony $ ______________________

Other $ ______________________

TOTAL INCOME: $ ______________

Expenses

Monthly Home/Rental Pymnt: $ __________

Medical Ins. Premium $ __________

Utilities/Home Phone: $ __________

Food/Home/Personal Necessities $ __________

Child Support/Alimony: $ __________

Medical/Dental: $ __________

Transportation: $ __________

Child Care/Tuition: $ __________

Other: ________ $ __________

TOTAL EXPENSES: $ ______________

Living Wage Calculation: $ __________
(For office use only)

By signing this form, I authorize Barton Memorial Hospital to verify any information. I understand that I may be required to provide proof of the information requested. Additionally, I certify that all the statements made on this application are true and complete to the best of my knowledge. Should it be determined that the information I provided is incomplete, any discount on my bill may be reversed, and payment in full may be expected of me.

If I receive payment from an insurance company, worker's compensation or any third party, I agree to inform the hospital of such payment. Iunderstand that the hospital retains its right to collect the original, full billed charges should a third party provide full or partial payment for the hospital's services.

____

Signature of Patient or Legal Guardian Date

____

Signature of Spouse or Domestic Partner Date

*This document is to be completed by the patient's legal guardians if the patient is a minor.

LIST OF REQUIRED ITEMS

Date: ___________________

Account number(s) ____________________

____

Dear _______________________________,

As you are aware, Barton Memorial Hospital provides quality healthcare services to our community and visitors. It is our desire to assist you in payment of your account(s) as soon as possible. Our Financial Assistance Program (income based financial assistance) may enable you to satisfy your account(s), depending on the information provided regarding your financial status.

If you are interested in this program, please fill out the enclosed form **COMPLETELY**, including this cover letter, and return with application.

1. Financial Information:

    - Income tax form for you and your spouse or domestic partner.
    - 2 most recent pay stubs for you and your spouse or domestic partner.

IMPORTANT

If your completed application is not returned by ____________________, a customer service representative will contact you to offer assistance.

If you need assistance qualifying for healthcare coverage, please do not hesitate to contact us.

If you have further questions concerning the Financial Assistance Program, please do not hesitate to contact us at:
(530) 543-5930.
(530) 541-2604 fax
We will advise you of the status of your application and options available.

Sincerely

Customer Service Representative

NOTIFICATION FORM

ELIGIBILITY DETERMINATION FOR THE BARTON MEMORIAL HOSPITAL FINANCIAL ASSISTANCE PROGRAM

Barton Memorial Hospital has conducted an eligibility determination for Financial Assistance for:

PATIENT NAME

ACCOUNT NUMBER

DATES OF SERVICE

The request for Financial Assistance was made by the patient or on behalf of the patient on ____________. This determination was completed on ________________.

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

Your request for Financial Assistance has been approved for services rendered on _____________

After applying the Charity Care reduction, the amount owed is $ _________________.

Extended interest free payment plan is available for any balance owed. Please call Customer Service at (530)543-5930 for assistance.

Your request for Financial Assistance has been denied for the following reason(s): ____

☐ *FAP final determination sent to Barton Memorial Hospital's Emergency Physicians billing company*

Granting of Financial Assistance is conditioned on the completeness and accuracy of the information provided to the hospital. In the event the hospital discovers you were injured by another person, you have additional income, you have additional insurance or provided incomplete or inaccurate information regarding your ability to pay for the services provided, the hospital may revoke its determination to grant Financial Assistance and hold the you and/or third parties responsible for the hospital's charges. If you have any questions on this determination, please contact:

Barton Memorial Hospital's Customer Service Department Supervisor (530) 543-5777

FEDERAL POVERTY LEVEL GUIDELINES

BARTON HEALTHCARE SYSTEM
ELIGIBILITY DETERMINATION FOR FINANCIAL ASSISTANCE PROGRAM

Eligibility Guide for 2017: Using household income and size as calculated in the Attachment A identify eligibility for financial discount.

Sliding Scale			100%	75%	50%	25%
		2017 100% Poverty Income	adjustment	adjustment	adjustment	adjustment
		Level-Yearly	200% and below	< 250%	< 300%	< 350%
	1	$12,060	$24,120	$30,150	$36,180	$42,210
Size of	2	$16,240	$32,480	$40,600	$48,720	$56,840
Family	3	$20,420	$40,840	$51,050	$61,260	$71,470
Unit	4	$24,600	$49,200	$61,500	$73,800	$86,100
	5	$28,780	$57,560	$71,950	$86,340	$100,730
	6	$32,960	$65,920	$82,400	$98,880	$115,360
	7	$37,140	$74,280	$92,850	$111,420	$129,990
	8	$41,320	$82,640	$103,300	$123,960	$144,620
*						

***Add $4,180 for each person over 8**