Barlow Respiratory
HOSPITAL

BARLOW RESPIRATORY HOSPITAL
FINANCIAL ASSISTANCE CHECKLIST

The attached financial assistance application is to determine your eligibility for charity care or discounted medical services at our facility. You must complete this form and return it with copies of all the required documentation (see list and the attached application). Items required for your specific application are marked with an "X." If we do not receive the completed application by the date specified, your application may be denied.

Financial assistance application must be returned by: _____.

Application must be delivered to the Business Services Department at our Barlow Main location, or mailed to:

BARLOW RESPIRATORY HOSPITAL
ATTENTION: BUSINESS SERVICES
2000 STADIUM WAY
LOS ANGELES, CA 90026-2696

Checklist of required information: (Copies only – no originals):

_____ Recent pay stubs or the most recent income tax return.

_____ Medi-Cal denial notice.

_____ Unemployment compensation determination or termination notice.

_____ Complete listing of all currently outstanding medical debt.

_____ Complete listing of all out-of-pocket costs incurred over past 12 months.

Have you:

1. Completed the financial assistance application?_____

2. Signed the financial assistance application?_____

Please use this checklist to make sure your application is complete.

Please note that your signature verifies the accuracy of the information provided and authorizes Barlow Respiratory Hospital to verify any and all information provided

Signature:_____

FINANCIAL ASSISTANCE APPLICATION

Patient Name:_____ Spouse:_____

Address: _____

Phone:_____

Social Security Number:_____ Driver License #: _____

If you are **over** 18, please list (i) your spouse (or domestic partner) and (ii) dependent children who are under the age of 21			
Name	Age	Relationship (spouse, domestic partner, dependent)	Annual Income of such person

If you are **under** 18, please list (i) your parents (or if other relatives take care of you, list them) and (ii) any other children under the age of 21 of your parents or relatives who take care of you			
Name	Age	Relationship (parent, caretaker relative, children)	Annual Income

Family Income

What is your total family income (taking into account your income as well as the income of those family members listed above)? _____

Please attach recent pay stubs or your most recent income tax return.

Existing Insurance

Do you have any health insurance, such as Medicare, Medi-Cal or private health insurance?

Yes:____ No:_____ Payor:_____

Is your injury covered by workers' compensation, automobile insurance, or other insurance?

Yes:____ No:_____

Please provide any documentation in support of your answers above.

Annual Medical Costs

How much have you paid in medical costs over the past 12 months to:

Barlow Respiratory Hospital:_____ (please attach supporting documentation)

Other Providers:_____ (please attach supporting documentation)

My signature on this form verifies the accuracy of the information provided and authorizes Barlow Respiratory Hospital to verify any and all information provided.

I understand that any financial assistance is intended solely for my benefit and does not relieve third parties or liability for payment.

I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the services rendered by Barlow Respiratory Hospital. It is also understood that I may appeal the determination of whether I qualify for financial assistance in writing with additional documentation.

_____ _____

Date Signature of Patient or Legal Guardian

FINANCIAL ASSISTANCE APPROVAL FORM

Department Requesting Charity Care or Discount: Date Requesting_____

Admitting____ Business Services____ Case Management____ Physicians____ Social Services____

Patient Name:_____ Account #:_____

Social Security #_____
Admit Date:_____Discharge/Expected Discharge Date_____

Patient Type: ICU ICUV MedV Med Rehab.

Patient Resources:

Is the patient's ***Family Income***[1] equal to or less than 350% of the ***Federal Poverty Level***?[2]

Yes:____ No:____

Is the patient's ***Family Income*** equal to or less than 200% of the ***Federal Poverty Level***?

Yes:____ No:____

Is the patient a ***Self-Pay Patient***?[3]

Yes:____ No:____

Is the patient a ***Patient with High Medical Costs***?[4]

Yes:____ No:____

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[1] "***Family income***" means the patient's income, together with the income of the following: (1) for patients 18 years and older: the patient's spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (2) for patients under 18 years old: the patient's parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

[2] "***Federal poverty level***" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

[3] "***Self–pay patient***" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the Hospital.

[4] "***Patient with high medical costs***" means a person who does not receive a discounted rate from the Hospital as a result of his or her third-party coverage, when either of the following apply: (1) annual out-of-pocket costs incurred by the patient, at the Hospital, exceed 10% of the patient's ***family income*** in the prior 12 months, or (2) annual out-of-pocket medical expenses incurred by the patient, anywhere, exceed 10% of the patient's ***family income***, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

Patient Eligibility

Based on the forgoing, the patient is eligible for (check which applies):

Charity Care:_____. The patient is eligible for charity care because he or she has a ***Family Income*** equal to or less than 200% of the ***Federal Poverty Level*** and is either a ***Self-Pay Patient*** or is a ***Patient with High Medical Costs***. If the patient is eligible for charity care, the patient will not be charged for any medical services rendered.

Discounted Care:_____. The patient is eligible for discounted care because he or she has a ***Family Income*** equal to or less than 350% of the ***Federal Poverty Level*** and is either a ***Self-Pay Patient*** or is a ***Patient with High Medical Costs***.

Comments: _____

_____

_____

_____

CEO or CFO Approval_____ Date_____

PATIENT NOTIFICATION LETTER

Date: _____

Guarantor Name: _____

Patient Name: _____

Guarantor City, State and Zip Code: _____

Dear Mr. /Mrs. /Ms.: _____

We have carefully reviewed your application for financial assistance and have determined that your account:

( ) Meets the hospital's established guidelines for financial assistance.

( ) Meets the hospital's established guidelines for financial assistance pending outcome/resolution of your Medi-Cal application/financial review.

( ) Approved amount $_____. Your account will be reduced by _____%, and the guarantor is responsible for $ _____.

( ) Does not meet the hospital's established guidelines for financial assistance.

Reason for denial:

_____ Family income exceeds qualifications.

_____ Potential third-party payer source.

_____ Application not complete.

_____ Supporting documentation not adequate.

(Use this language in denial letters only)

If you wish to appeal this decision, please call the Manager, Patient Financial Services At: 213-202-6884 to initiate the appeals process.

(Use this letter for qualifying individuals only)

As a nonprofit hospital, we are proud of our support of the community and the charity care and discounted care we provide to you and others. We appreciate your choosing Barlow Respiratory Hospital for your health care needs and we welcome the opportunity to provide services to you in the future.

Sincerely,

BUSINESS SERVICES DEPARTMENT
BARLOW RESPIRATORY HOSPITAL