Barton Financial Counselor
2170 South Avenue
South Lake Tahoe, CA 96150

530.539.6086TEL
530.541.0554FAX
bartonhealth.org/financialassistance

How to Apply for Financial Assistance Program

Thank you for choosing Barton Health as your healthcare provider. We understand that medical bills can be burdensome and applying for assistance can be confusing. Barton offers different ways to help patients pay for their care by providing financial assistance, based on household income. **We may be able to help you with all or part of your financial responsibility, based on your eligibility.**

Patients who qualify for financial assistance will have:

- An annual family income that is less than or equal to 400% of the federal poverty level, as determined by guidelines published annually by the U.S. Department of Health and Human Services;
- Met with with a Barton Financial Counselor to explore eligibility for other programs, such as: Workers' Comp, Medi-Cal, and Victims of Crime; and
- Completed a Financial Assistance Program application and provided supporting documentation to verify income.

In order to determine your eligibility for financial assistance, you will need to complete the Financial Assistance application and provide additional documents to process your eligibility, including:

- Copy of prior year's income tax return (Form 1040) for you and your spouse or domestic partner.
- Copy of two (2) most recent pay stubs for you and your spouse or domestic partner.
- A letter explaining your financial situation and why you are seeking assistance.

Your completed financial assistance application and supporting documents may be returned by email to financialassistance@bartonhealth.org, via fax to 530-541-0554, in person to the Financial Counselor located at the Admitting department within Barton Memorial Hospital and also by mail to:

Barton Financial Counselor
2170 South Avenue
South Lake Tahoe, CA 96150

Barton will make every effort to process your application promptly and determine your eligibility for financial assistance. Once your application has been reviewed, you will receive a letter to notify you of the outcome.

If you have questions concerning Barton's Financial Assistance Program, need assistance completing the application, or would like to talk about additional options, please do not hesitate to contact a Barton Health Financial Counselor at 530.539.6086.

2022 Federal Poverty Level Guidelines
Eligibility Guide for Financial Assistance Program

Eligibility Table

Using household income and size as calculated in the table below to identify eligibility for financial discount.

Sliding Scale			100%	75%	50%	25%
		2022 100% Poverty Income				
		Level-Yearly	Below	250- 300%	300-350%	350-400%
Size of Family Unit	1	$13,590	$27,180	$33,975 - $40,770	$40,770 - $47,565	$47,565 - $54,360
	2	$18,310	$36,620	$45,775 - $54,930	$54,930 - $64,085	$64,085 - $73,240
	3	$23,030	$46,060	$57,575 - $69,090	$69,090 - $80,605	$80,605 - $92,120
	4	$27,750	$55,500	$69,375 - $83,250	$83,250 - $97,125	$97,125 - $111,000
	5	$32,470	$64,940	$81,175 - $97,410	$97,410 - $113,645	$113,645 - $129,880
	6	$37,190	$74,380	$92,975 - $111,570	$111,570 - $130,165	$130,165 - $148,760
	7	$41,190	$83,820	$104,775 - $125,730	$125,730 - $146,685	$146,685 - $167,640
	8	$46,630	$93,260	$116,575 - $139,890	$139,890 - $163,205	$163,205 - $186,520
For Each Add'l Person Add		4,480	11,199	11,200	13,440	17,920

Date Application Received: ___________

Barton Health
Financial Assistance Application

Patient Name: ___________________________ **Date of Application:** ________________

Barton Health
Account Number(s): ___________________________ Date(s) of Service: ________________________

Responsible Party* Information:

Name: ___________________________
Address: ___________________________
____
Phone: ___________________________
SSN/TIN: ___________________________
Employer: ___________________________

Spouse / Domestic Partner Information:

Name: ___________________________
Address: ___________________________
____
Phone: ___________________________
SSN/TIN: ___________________________
Employer: ___________________________

Marital Status (check one box):

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

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

Barton Health
Financial Assistance Application

Monthly Household Income:

Gross monthly income from wages (before deductions)	$ ____________
Social Security	$ ____________
Unemployment Compensation	$ ____________
Child Support / Alimony	$ ____________
Other	$ ____________
TOTAL MONTHLY INCOME	**$** ____________

Monthly Household Expenses:

Monthly Mortgage or Rent Payment	$ ____________
Medical Insurance Premium	$ ____________
Medical / Dental Expenses (other than insurance)	$ ____________
Child Care / Tuition	$ ____________
Transportation (car, bus, taxi)	$ ____________
Utilities – Electricity, Gas, Water & Telephone	$ ____________
Food / Home / Personal Necessities	$ ____________
Child Support / Alimony	$ ____________
Other:	$ ____________
TOTAL MONTHLY EXPENSES	**$** ____________

Living Wage Calculation: *(For office use only)* $ ____________

By signing this form, I authorize Barton Health 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 Barton Health of such payment. I understand that Barton Health retains its right to collect the original, full billed charges should a third party provide full or partial payment for the medical 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.