



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

530.539.6086TEL  
530.541.0554FAX  
[bartonhealth.org/financialassistance](http://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 in person to the Financial Counselor located at the Admitting department within Barton Memorial Hospital or 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.





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## 2020 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.

Financial Assistance Level			100%	75%	50%	25%
		2020 Federal Poverty Income Level-Annual	Below	250 - 300%	300 - 350%	350 - 400%
Size of Family Unit	1	12,760	31,899	31,900 – 38,280	31,281 – 44,660	44,661 – 51,040
	2	17,240	43,099	43,100 – 51,720	51,721 – 60,340	60,341 – 68,960
	3	21,720	54,299	54,300 – 65,160	65,161 – 76,020	76,021 – 86,880
	4	26,200	65,499	65,500 – 78,600	78,601 – 91,700	91,701 – 104,800
	5	30,680	76,699	76,700 – 92,040	92,041 – 107,380	107,381 – 122,720
	6	35,160	87,899	87,900 – 105,480	105,481 – 123,060	123,061 – 140,640
	7	39,640	99,099	99,100 – 118,920	118,921 – 138,740	138,741 – 158,560
	8	44,120	110,299	110,300 – 132,360	132,361 – 154,420	154,421 – 176,480
For Each Add'l Person Add**		4,480				

**\*\*For each additional person add \$4,480 for annual income.**



# Barton Health Financial Assistance Application

**Patient Name:** \_\_\_\_\_ **Date of Application:** \_\_\_\_\_

Barton Health  
Account Number(s): \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

**Responsible Party\* Information:**

**Spouse / Domestic Partner Information:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

SSN/TIN: \_\_\_\_\_

SSN/TIN: \_\_\_\_\_

Employer: \_\_\_\_\_

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	\$ _____
<b>TOTAL MONTHLY INCOME</b>	<b>\$ _____</b>

## 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:	\$ _____
<b>TOTAL MONTHLY EXPENSES</b>	<b>\$ _____</b>

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.