BARTON HEALTHCARE SYSTEM FINANCIAL ASSISTANCE PROGRAM

CONFIDENTIAL FINANCIAL STATEMENT AND FINANCIAL ASSISTANCE APPLICATION

Patient Name: ____

Account Number(s):_________________________ Date of Service(s): __________________

Responsible Party*

Name ____________________________

Address: ____________________________

____

Phone: ____________________________

SSN/TIN: ____________________________

Employer: ____________________________

Spouse or Domestic Partner

Name ____________________________

Address: ____________________________

____

Phone: ____________________________

SSN/TIN: ____________________________

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:
1.____________________________	______	________________________________
2.____________________________	______	________________________________
3.____________________________	______	________________________________
4.____________________________	______	________________________________
5.____________________________	______	________________________________
6.____________________________	______	________________________________

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. I understand 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.

FEDERAL POVERTY LEVEL GUIDELINES

BARTON HEALTHCARE SYSTEM
ELIGIBILITY DETERMINATION FOR FINANCIAL ASSISTANCE PROGRAM

Eligibility Guide for 2019: Using household income and size as calculated in the Attachment A identify eligibility for financial discount.

Sliding Scale			100%	75%	50%	25%
		2019 100% Poverty Income				
		Level-Yearly	Below	200 - 250%	250- 300%	300 - 350%
	1	12,490	24,979	24,980 – 31,225	31,226 – 37,470	37,471 – 43,715
Size of	2	16,910	33,819	33,820 –42,275	42,276 – 50,730	50,731 – 59,185
Family	3	21,330	42,659	42,660 – 53,325	53,326 – 63,990	63,991 – 74,665
Unit	4	25,750	51,499	51,500 – 64,375	64,376 – 77,250	77,256 – 90,125
	5	30,170	60,339	60,340 – 75,425	75,426 – 90,510	90,516 – 105,595
	6	34,590	69,179	69,180 – 86,475	86,476 – 103,770	103,771 – 121,065
	7	39,010	78,019	78,020 – 97,525	97,526 – 117,030	117,031 – 136,535
	8	43,430	86,859	86,860 – 108,575	108,576 – 130,290	130,291 – 152,005
For Each Add’l Person Add		4,420				

The 350% threshold represents the minimum required to be offered to low-income uninsured patients; Barton Health may adopt a higher income threshold.

For each additional person add $4,420 for annual income. Barton Hospital Inpatient Outpatient

NOTIFICATION FORM

BARTON MEMORIAL HOSPITAL
ELIGIBILITY DETERMINATION FOR THE BARTON MEMORIAL HOSPITAL FINANCIAL ASSISTANCE PROGRAM

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

___________________________________ ____

PATIENT'S NAME ACCOUNT NUMBER

____

DATE(S) 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 Financial Assistance reduction, the amount owed is $ _________________.

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

You may also pay your balance online at bartonhealth.org

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

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) 541-8723 fax

We will advise you of the status of your application and options available.

Sincerely
Customer Service Representative