Bay Area Hospital

# Financial Assistance Policy – Plain Language Summary

Bay Area Hospital's Financial Assistance Policy (FAP) exists to provide patients with a variety of options to choose from in order to resolve their financial liability for services rendered.

**Financial assistance options are as follows:**

- Hospital Bill Reduction (HBR) using Amount Generally Billed (AGB) Discount (http://www.bayareahospital.org/Financial-Services).
- Federal Poverty Level (FPL) Discount
- Un-insured Discount (for patients not eligible for AGB Discount)
- Prompt Pay Discount

**Eligibility for HBR Discount**: Eligibility for HBR discount will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of HBR discounts shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. An HBR discount approval covers current accounts for services covered under this policy with a balance due. The HBR discount approval also applies to services covered under this policy for twelve months from the date of approval. Bay Area Hospital reserves the right to request a new HBR application at any time. Eligibility for the HBR discount will be determined by evaluating family income, family size and the current calendar year federal poverty level. Patients in families whose applicable family income is below the federal poverty level for the size of the family, will be considered eligible for the HBR discount.

**Services Eligible for HBR**:

- Emergency medical services provided in an Emergency Department setting;
- Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
- Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
- Medically necessary services, evaluated on a case-by-case basis at Bay Area Hospital's discretion.

**How to Apply for the HBR**: Applying for HBR may be done prior to services or within two hundred forty (240) days from the first patient balance statement mail date. HBR applications may be obtained in the Hospital from the Patient Access and Patient Accounts departments; or printed from www.bayareahospital.org; and are included with certain patient statements. You may receive additional information on the application in the Patient Accounts department in the Hospital.

Applicants who qualify for the HBR discount will not be required to pay more than the Amounts Generally Billed for the eligible services (emergency or other medically necessary care) received. Applicants approved for HBR discount are also eligible for an additional discount depending on family income as a percentage of current federal poverty levels.

A free copy of the full Financial Assistance Policy is available to the public at www.bayareahospital.org/Financial-Services or upon request, in person or in writing, by contacting the Patient Accounts department at (541) 269-8131. Copies are available in English, and Spanish.

Patients not eligible for the HBR discount may be eligible for other discounts such as the Un-insured discount and the Prompt Pay discount. Please contact the Patient Accounts department for details

Bay Area Hospital

# Financial Assistance - HBR Application Form Instructions

This is an application for financial assistance (also known as Hospital Bill Reduction) at Bay Area Hospital.

**The State of Oregon requires all hospitals to provide financial assistance** to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance.

**What does financial assistance cover?** The hospital financial assistance covers appropriate hospital-based services provided by Bay Area Hospital depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

**If you have questions or need help completing this application:** Please contact the Patient Accounts Department at (541) 269-8131 for assistance in completing this application. You may obtain help for any reason, including disability and language assistance.

**In order for your application to be processed, you must:**

- ☐ **Provide us information about your family**
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- ☐ **Provide us information about your family's gross monthly income (income before taxes and deductions)**
- ☐ **Provide documentation for family income and declare assets**
- ☐ **Attach additional information if needed**
- ☐ **Sign and date the form**

**Note**: **You do not have to provide a Social Security number to apply for financial assistance**. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

**Mail or fax completed application with all documentation to:** Bay Area Hospital, 1775 Thompson Road, Coos Bay, OR 97420, attn. Patient Accounts Department, or fax to (541) 269-8517. Be sure to keep a copy for yourself.

**To submit your completed application in person**: Patient Accounts Department, (541) 269-8131.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

**We want to help. Please submit your application promptly!**
**You may receive bills until we receive your information.**

Bay Area Hospital

# Financial Assistance - HBR Application Form – confidential

*Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.*

## SCREENING INFORMATION

Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? □ **Yes** □ **No** *May be required to apply before being considered for financial assistance*

Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** □ **No**

Is the patient currently homeless? □ **Yes** □ **No**

Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**

## PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

## PATIENT AND APPLICANT INFORMATION

| Patient first name | Patient middle name | | Patient last name |
|---|---|---|---|
| □ Male □ Female<br>□ Other (may specify ______________) | Birth Date | | Patient Social Security Number (optional*)<br>**optional, but needed for more generous assistance above state law requirements* |
| Person Responsible for Paying Bill | Relationship to Patient | Birth Date | Social Security Number (optional*)<br>**optional, but needed for more generous assistance above state law requirements* |
| Mailing Address<br>______________________________<br>______________________________<br>City State Zip Code | | | Main contact number(s)<br>( ) ____________________<br>( ) ____________________<br>Email Address:<br>______________________________ |

Employment status of person responsible for paying bill

□ **Employed** (date of hire: ______________________) □ **Unemployed** (how long unemployed:________________________)

□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (________________________)

## FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. **FAMILY SIZE** ____________ *Attach additional page if needed*

| Name | Date of Birth | Relationship to Patient | If 18 years old or older: Employer(s) name or source of income | If 18 years old or older: Total gross monthly income (before taxes): | Also applying for financial assistance? |
|---|---|---|---|---|---|
| | | | | | Yes / No |
| | | | | | Yes / No |
| | | | | | Yes / No |
| | | | | | Yes / No |

**All adult family members' income must be disclosed. Sources of income include, for example:**

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain*______________)



1775 Thompson Road, Coos Bay, OR 97420
www.bayareahospital.org

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# Bay Area Hospital

## Financial Assistance - HBR Application Form – confidential

### INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

**You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.**

**Examples of proof of income include:**

- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

### EXPENSE INFORMATION

*We use this information to get a more complete picture of your financial situation.*

Monthly Household Expenses:

Rent/mortgage $________________________ Medical expenses $________________________

Insurance Premiums $________________________ Utilities $________________________

Other Debt/Expenses $________________________ (*child support, loans, medications, other*)

### ASSET INFORMATION

*This information may be used if your income is above 101% of the Federal Poverty Guidelines.*

Current checking account balance

$______________________________

Current savings account balance

$______________________________

Does your family have these other assets?

**Please check all that apply**

□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)

□ Property (excluding primary residence) □ Own a business

### ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

### PATIENT AGREEMENT

I understand that Bay Area Hospital may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

______________________________________________ ______________________________

Signature of Person Applying Date



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