Appendix A: Financial Assistance Application / Determination of Eligibility

Dear Applicant,

To enable Baptist Health to evaluate your financial situation and expedite the financial assistance approval process, please ensure that you review the following requirements, complete the application, and return the requested information within thirty (30) days. A checklist is provided to assist you. **All elements of the application must be completed as applicable to the person applying for financial assistance.**

1) The completed Financial Assistance Application (attached to this letter)
2) Proof of applicant's income, spouse's income, and proof of income for any family member related by birth, marriage or adoption, over the age of 18 years living with you.
    a. Previous year's federal signed tax return.
    b. If exempt from filing tax returns; provide 1099s & W2s as proof of income on interests, dividends, pensions, rents, and social security.
    c. Copies of two (2) months of your most recent pay stubs or a notarized letter from your employer on company letterhead verifying gross income.
    d. Proof of any income not on federal tax return such as alimony, child support, unemployment, pension, Social Security Award letter.
3) If you receive no income (e.g., not receiving any unemployment benefits), but are being supported by one of the following :
    a. Relatives or friends- a letter explaining these arrangements is required.

    The person lending assistance must sign the letter.

    b. Any form of government assistance such as food stamps, housing subsidies, utilities, HUD, Section 8 - a copy of the relevant document from the government is required.
4) Proof of non-eligibility for Medicaid if screened by the Baptist eligibility vendor.
5) Proof of assets: current statements from your bank for savings & checking accounts, copy of IRA Certificate, investments, Certificate of Deposit (CDs), and any other assets as applicable.

Once you have completed the enclosed application and collected all items listed in the checklist, please mail the information to:

Baptist Health Financial Assistance
PO Box 241145
Montgomery, AL 36124

Call (334) 747-4270 if you need help completing the application or have any questions about the items requested.

Failure to return the requested information will result in the denial of this application.

Falsification of any information on the Financial Assistance Application will result in financial assistance becoming null and void.

Financial Assistance Checklist
(Please Print)

Patient Name: _____
(Last) (First) (MI)

Account # (from your bills): _____

Social Security # or Residential Visa #:_____

☐ Completed Financial Assistance Application

☐ Proof of Income for all family members related by birth, marriage or adoption, over the age of 18 years living with you

- ☐ Previous year's federal signed tax return
- ☐ 1099s & W2s for interests, dividends, pensions, rents, social security (If exempt from filing tax)
- ☐ Copies of two (2) months of your most recent pay stubs
- ☐ Proof of any income, not on previous federal tax return, such as unemployment, alimony, pension, Social Security Award letter if applicable. Circle item(s) that apply.

☐ Proof of non-eligibility for Medicaid

☐ Proof of assets (e.g., current statements from your bank for savings & checking accounts, copy of IRA Certificate, copy of recent home appraisal, investments, Certificate of Deposit (CDs) and any other assets as applicable)

Financial Assistance Application
(Please Print)

Patient Information

Date: _____

Name: _____ Social Security #:_____
(Last) (First) (MI)

Marital Status: Married_____/ Single_____/ Divorced_____/ Widowed_____/ Separated_____

D/O/B: _____/_____/_____
(MM/DD/YYYY)

Present Address: _____
(Street/Apt Number) (City) (State) (Zip)

Previous Address: _____
(Street/Apt Number) (City) (State) (Zip)

Telephone Number: (_____) _____ (_____) _____ (_____) _____
(Home) (Work) (Cell)

Email address _____

Responsible Party Information (if patient is under 19 years of age)

Name: _____ D/O/B: _____/_____/_____
(Last) (First) (MI)

Present Address: _____
(Street/Apt Number) (City) (State) (Zip)

Previous Address: _____
(Street/Apt Number) (City) (State) (Zip)

Telephone Number: (_____) _____ (_____) _____ (_____) _____
(Home) (Work) (Cell)

Relationship to Patient: _____ SOCIAL SECURITY #:_____

List all persons to be included in application process: **Please read instruction # 5 on the cover letter of the Financial Assistance Application packet before completing this section and ensure that you provide Annual Income of all earning family members.*

	Name	DOB	SS#	Annual Income
Applicant	_____	____/____/____	_____-____-_____	$_____
Spouse	_____	____/____/____	_____-____-_____	$_____
Dependent	_____	____/____/____	_____-____-_____	$_____
Dependent	_____	____/____/____	_____-____-_____	$_____
Dependent	_____	____/____/____	_____-____-_____	$_____
Dependent	_____	____/____/____	_____-____-_____	$_____
Dependent	_____	____/____/____	_____-____-_____	$_____

(Please list any additional legal dependents along with proof such as court order on separate sheet if applicable.)

Financial Assistance Application
(Please Print)

Name: _____

(Last) (First) (MI)

Please ensure that you provide proof of all information that you input in the sections below under Income, Assets, and Governmental Programs/ support. Please input N/A against items that do not apply to you.				
INCOME			**ASSETS**	
Description	**Monthly Income**		**Description**	**Value Amount**
Gross Salary for Applicant	**$**		**Home (Recent Appraised Value)**	**$**
Employer Name:			**Checking Account (Provide Current Month's statement)**	**$**
Gross Salary for Spouse	**$**		**Name of Bank(s)**	
Spouse's Employer Name:			**Savings Account (Provide Current Month's statement)**	**$**
Gross Salary for any other Family member less than 18 years of age	**$**		**Name of Bank(s)**	
Gross Salary for any other Family member over 18 years	**$**		**IRA (Provide copy of certificate)**	**$**
Dividend and Interest	**$**		**Other**	**$**
Rental Income	**$**		**TOTAL ASSETS**	**$**
Pension Income	**$**			
Alimony (Income)	**$**		**Complete if you do not show income or assets**	
Social Security Benefits	**$**		**Food Stamps**	
V.A. Benefits	**$**		**Housing subsidy**	
Income from estates, trusts	**$**		**HUD**	**$**
			Section 8	**$**
Other-	**$**		**Utilities**	**$**
TOTAL INCOME PER MONTH	**$**		**Help from relative, friends, or others to cover expenses such as Rent, Car, Apartment etc.**	**$**

I provide my consent and understand that the information I submit is subject to verification by Baptist Health and subject to review by state and/or federal enforcement agencies, , and other entities as required by law. I also understand that Baptist Health reserves the right to ask for additional information.

I certify under the statutes of perjury that the information on these pages is true and correct, and that I do not have the financial means to pay for medical care rendered to the above patient. If my financial situation changes in the upcoming calendar year, I will report these changes to the Baptist Health immediately.

My signature on this application verifies that if I am entitled to any other medical benefits, including, but not limited to, a supplemental insurance policy, I will provide Baptist Health with this information and understand that if I choose not to give any information regarding my supplemental insurance carrier, my application for assistance could be denied and I will be responsible for the total amount of all outstanding bills at Baptist Health. I read and understand what is not covered by financial assistance and I cannot request a further review/audit of my charges once financial assistance is approved.
***Financial Assistance does not include Medications prescribed for patients to self-administer upon discharge.**

I give Baptist Health permission to email my approval/denial letter (if email address is provided).

Signature of Responsible Party: _____ Date: _____

Financial Assistance Application
(Please Print)

Name: _____
(Last) **(First)** **(MI)**

Insurance Information:

Do you or your spouse have health insurance? Yes☐ No ☐ If so, list below:

	Insurance Company	Policy #	Group #
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Is health insurance available to you through your employers? Yes☐ No ☐ N/A☐

Have you declined health insurance coverage offered to you by your employer or through responsible person's employer?
Yes☐ No ☐ N/A ☐

Have you received or do you expect to receive a Third Party Liability settlement related to an accident or injury resulting in your admission to Baptist Health? Yes☐ No ☐

If your visit at Baptist Health is the result of an accident or injury, are you represented by an attorney? Yes☐ No ☐

If "Yes," please complete the following:

Attorney Name: _____

Attorney Address: _____

_____

Attorney Telephone: _____

My signature below attests that the above information is valid and true.

Signature of Responsible Party: _____ **Date:** _____

Financial Assistance Application
(Please Print)

Name: _____
(Last) (First) (MI)

Financial Assistance does not cover the following services:

- Copays
- Reconstructive surgery which is not medically necessary
- Cosmetic surgery
- Breast implants
- Breast reduction
- Teeth extractions (excluding radiation, transplant patients or extractions due to trauma.)
- Weight loss surgery
- Genetic testing that is required for determining treatment will be covered, but all other genetic testing will be charged to the patient.
- Medications prescribed for patients to self-administer upon discharge.
- Durable medical equipment
- Routine Physical Exams
- Services not normally covered by health insurance

These are examples of services not covered under Financial Assistance Program.

This list may not include all exclusions to the program.

Should you have questions regarding your particular plan of care, please feel free to call (334) 747-4270.

We reserve the right to change or update covered or non-covered services without notice.