



FINANCIAL ASSISTANCE APPLICATION

BATH COMMUNITY HOSPITAL ACCESS PROGRAM

To meet the continuing needs of its service community, Bath Community Hospital has adopted a financial assistance program to assist its patients in resolving hospital accounts. All hospital services are included, both inpatient and outpatient. *This policy does not cover convenience items, drugs from the pharmacy or services that are not medically necessary as determined by the provider.*

To be considered eligible for financial assistance, your household income must be at or below the following levels (effective April 1, 2009):

FEDERAL POVERTY GUIDELINE FAMILY 12-MONTH SIZE	INCOME
1	\$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

More than 8, add \$3,740 for each additional member

Bath Community Access Network Sliding Fee Scale

Level of Income – Reduction Amount		
0%-150%	of Federal Poverty Guidelines	100%
151-200%	of Federal Poverty Guidelines	50%
201%-250%	of Federal Poverty Guidelines	25%
251%-300%	of Federal Poverty Guidelines	10%
301%-350%	of Federal Poverty Guidelines	5%

Dependent upon the family income level and household size, the charges could be reduced or eliminated. You may be responsible for a portion of your bill, even though you have been approved. **NOTE: It is the patient's responsibility to notify BCH of any services received during the approval period.**

As a further condition of eligibility you must make application for any assistance (Medicare, Medicaid, medical insurance, auto insurance, etc.) that may be available for payment of your hospital charge. You must take any action reasonably necessary to obtain such assistance and assign or pay to the hospital the amount recovered for hospital charges. **There are no exceptions to this rule.** If your charges are pending legal action by your attorney, or are considered to be workers compensation claims, they are not eligible for financial assistance.

If you think you may be eligible for financial assistance, you may complete the enclosed form, and submit it to the Business Office of Bath Community Hospital. Bath Community Hospital will make a written determination of your eligibility for financial assistance and notify you by mail of the determination. Should you disagree with the determination you have the right to appeal.

Complete applications can be mailed to:

Bath Community Hospital
PO Drawer Z
Hot Springs, VA. 24445

BATH COMMUNITY ACCESS PROGRAM

FINANCIAL ASSISTANCE APPLICATION FORM INSTRUCTIONS

STEP 1: This portion of the application identifies the patient requesting financial assistance. Enter the patient information requested completely and accurately.

STEP 2: This portion of the application identifies all of the members of the household and any income that is earned by those members. Enter income information for all household members.

Note: The following **are** considered a member of a household for financial assistance purposes:

- Patient
- Spouse
- Minor children
- Disabled children over the age of 18
- Grandchildren, if custody is awarded to the grandparents

The following are **NOT** considered a member of the household for financial assistance purposes:

- Unmarried boyfriend or girlfriend of patient
- Grandchildren, if custody has not been awarded to the grandparents
- Any child for which you have not been awarded custody
- Children over the age of 18 who are not disabled

Also in this section, record whether or not you receive unemployment, child support, etc. and the amounts of the assistance. If you are unemployed and do not receive any financial assistance, then you must provide a letter from the person(s) who provide you with support (food, shelter, etc.).

You will be required to provide proof of income for the household. The following is a list of required documentation.

- Pay check stubs or letter from employer(s) verifying income. Additionally, you may also be required to provide your most recent tax return statement.
- Verification of unemployment income.
- Verification of SSI, disability, workers compensation, social security, pension or other benefit related income programs.
- Copies of child support or alimony checks.
- If self-employed, you must provide your most recent tax return, including ALL associated schedules.

*Additional documentation may be required depending on your situation and circumstances

Please contact Stephanie Pritt at Bath Community Hospital Business office (540) 839-7072 if you have any questions.



PO Drawer Z
 Hot Springs, VA. 24445
 Contact: Stephanie Pritt (540) 839-7072

Financial Assistance Application

Patient Name:	Soc. Sec. No:
Address:	Birthdate:
City, State, Zip	Telephone:
Marital Status: (circle one) Single Married Divorced Separated Widowed	

Step 2: Fill out all income information. Provide income information for the past 12 months. If additional space is required attach a separate sheet.

Family Members Include Self, Spouse, Children under 18	Date of Birth	Relationship to Patient

If unemployed, provide date employment ended _____

Have you applied for unemployment? _____

Does anyone in your household receive any of the following types of assistance?

You will need to provide proof of the amount of this assistance

Medicaid/Famis: Yes/No Amt.: _____ Work Comp Benefits: Yes/No Amt.: _____

Child support: Yes/No Amt.: _____ Disability: Yes/No Amt.: _____

Alimony: Yes/No Amt.: _____

- NOTE: 1. You MUST attach proof of income as requested above.**
2. Bath Community Hospital reserves the right to request further income information.
3. If you have zero income: attach written explanation as to who provides your room and board.
4. Social Security recipients, you must provide your gross Social Security amount.

CERTIFICATION

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, medical Insurance, auto Insurance, etc.) that may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Date of Request _____

Applicant's Signature _____

**Please refer to the back of this form for additional information to assist you in completing this application.*