Christian Health

FINANCIAL ASSISTANCE APPLICATION

(To be completed by Patient/Resident/Client, Sponsor or Admissions Coordinator)

Date of Application:_____ Admission Date_____

Program Submitting Application:_____

Patient/client's Name:_____Date of Birth:_____

Name of Guarantor (if other than patient/client):_____

Address of Patient/client:_____
Street Town State Zip

Telephone#_____

Reason for Request:_____

_____

Name of Person Requesting Financial Assistance:_____

Insurance Information (If none please note):_____

_____

Dependents:	Name:			
	SS#:			
	Relationsl			
	Age:			

INCOME- Patients must meet both the income and assets criteria (Refer to eligibility criteria below)
When determining eligibility for financial assistance, a husband and wife's income must be used for an adult, and combined parents income must be used for a minor child.

Patient/client/family gross income equals the lesser of the following:
Last twelve (12) months:_____or last three (3) months x 4: $_____

Income Includes:

Wages before deductions	$_____
Dividends	$_____
Social Security	$_____
Public assistance/unemployment	$_____
Alimony/child support	$_____
Other income:_____	$_____

NOTE: Refer to Required Document Checklist below and attach the required documents.

ASSETS Patients must meet both the income and assets criteria. Refer to the Eligibility Criteria on page 4.

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When determining eligibility for financial assistance, a husband and wife's assets must be used for an adult, and combined parents assets must be used for a minor child.

Liquid Assets Includes:

Cash	$_____
Savings accounts	$_____
Checking accounts	$_____
Other assets:_____	$_____

NOTE: Refer to Required Document Checklist below and attach the required documents.

LIABILITIES

Current monthly rent payment	$_____
Current monthly mortgage payment	$_____
Current monthly home equity payment	$_____
Credit card debt (Total)	$_____
Other outstanding loan payments	$_____
Outstanding medical bills	$_____
Other (please specify):_____	$_____
Total Liabilities	$_____

Is any other financial assistance available to you (i.e. church)? ☐ Yes ☐ No

If "Yes", do we have your approval to contact the person/organization? ☐ Yes ☐ No

Person/organization to contact_____ Phone #_____

Prepared by:_____ Relationship to Patient:_____

Applicant's Signature_____ Date:_____

FAP DETERMINATION-To Be Completed by CH Staff

Finance Department Staff:

Approved: ☐ Yes ☐ No ☐ Free Care ☐ Sliding Fee Scale Amount or %_____

Director of Patient Accounting_____ Date_____

VP Revenue Cycle _____ Date_____

Mental Health Staff:

Administrator / Director_____ Date_____

Long Term Care / ☐Staff:

Administrator/Director_____ Date_____

NOTE: Attach additional sheets as needed.

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REQUIRED DOCUMENT CHECKLIST

To process your financial assistance application, additional information and documentation is required in addition to your completed application. Therefore, please submit the following documents with your completed application before the deadline:

☐ **HEALTH INSURANCE** – copies of your primary and secondary insurance cards (i.e. Medicare, Medicaid,Blue Cross, commercial insurance, etc.).

☐ **IDENTIFICATION** – two (2) forms of identification with signatures preferred (i.e.: driver's license, voter's registration card, passport, alien registration, or any picture ID). An insurance card can be used as one form of identification.

☐ **FAMILY SIZE** – list all family members, their social security numbers and dates of birth.

☐ **INCOME** – copies of pay stubs (three months prior to date of service or the most current showing year to date income), most current W2 form, social security benefits (print-out from Social Security Office or copies of social security checks), proof of unemployment/public assistance, and any other source of income.

☐ **ASSETS** – copies of bank statements for checking, savings accounts and CDs as well as copies of financial statements from other financial institutions that you have investment accounts with.

☐ **TAX RETURN**- copy of the last tax return you filed and last year's W2 form.

☐ **NOTARIZED LETTER**- If no income and/or asset information is available, a notarized letter detailing your financial circumstances may be acceptable.

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CHARITY CARE AND REDUCED CHARITY CARE ELIGIBILITY CRITERIA

Effective: March 15, 2024

Patients Must Meet Both The Income and Assets Criteria

INCOME CRITERIA

Percentage of Rate Paid By Patient When
Gross Annual Income is Within the Following Ranges

	Patient Pays 0% of Rate	Patient Pays 20% of Rate	Patient Pays 40% of Rate	Patient Pays 60% of Rate	Patient Pays 100% of Rate	Patient Pays 100% of Rate
Family Size*	<=200%	>200<=225%	>225<=250%	>250<=275%	>275<=300%	>300%
1	**$30,120 or less**	**$30,121 to $33,885**	**$33,886 to $37,650**	**$37,651 to $41,415**	**$41,416 to $45,180**	**$45,181 or more**
2	**$40,880 or less**	**$40,881 to $45,990**	**$45,991 to $51,100**	**$51,101 to $56,210**	**$56,211 to $61,320**	**$61,321 or more**
3	**$51,640 or less**	**$51,641 to $58,095**	**$58,096 to $64,550**	**$64,551 to $71,005**	**$71,006 to $77,460**	**$77,461 or more**
4	**$62,400 or less**	**$62,401 to $70,200**	**$70,201 to $78,000**	**$78,001 to $85,800**	**$85,801 to $93,600**	**$93,601 or more**
5	**$73,160 or less**	**$73,161 to $82,305**	**$82,306 to $91,450**	**$91,451 to $100,595**	**$100,596 to $109,740**	**$109,741 or more**
6	**$83,920 or less**	**$83,921 to $94,410**	**$94,411 to $104,900**	**$104,901 to $115,390**	**$115,391 to $125,880**	**$125,881 or more**
7	**$94,680 or less**	**$94,681 to $106,515**	**$106,516 to $118,350**	**$118,351 to $130,185**	**$130,186 to $142,020**	**$142,021 or more**
8	**$105,440 or less**	**$105,441 to $118,620**	**$118,621 to $131,800**	**$131,801 to $144,980**	**$144,981 to $158,160**	**$158,161 or more**
For families with more than 8 members, add the following amounts to the highest amount in each column for each additional family member.						
	$10,760	**$12,105**	**$13,450**	**$14,795**	**$16,140**	
***A pregnant woman is counted as 2 family members.**						

If patients on the 20% to 80% sliding fee scale are responsible for qualified out-of-pocket paid medical expenses in excess of 30% of their gross annual income (i.e. bills unpaid by other parties), then the amount in excess of 30% is considered hospital payment assistance (charity care).

ASSETS CRITERIA

Individual assets cannot exceed $7,500 and family assets cannot exceed $15,000.