Bear Valley Community Healthcare District

Financial Assistance Evaluation Application

Charity Care/Financial Need Discount

This is an application for financial assistance (also known as charity care) at Bear Valley Community Healthcare District. You may qualify for financial assistance based on your family size and income, compared to the federal poverty level. Any information submitted for consideration of financial assistance will be treated as protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

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

Instructions: Complete all required information below including Patient Demographics, Employment, as well as Schedules 1, 2 and 3. Attach a copy of your most recent pay stubs, if self-employed evidence of your declared income [financial statement, bank statements and/or SBE tax return], a copy of your most recent W2(s) and the most recent filed and signed US income tax return(s) supporting your annual income. Please be sure to **sign** and **date** the completed application.

For assistance completing this application, please call the Patient Financial Services Offices at 909-878-8252 Monday thru Friday 7:30 AM until 5:00 PM.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 30 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.

Please submit your completed application either in person at Bear Valley Community Hospital, or by mail at PO Box 1649 Big Bear Lake, CA 92315.

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

PATIENT DEMOGRAHICS

Patient Account Number (s)

_____ _____

_____ _____

Patient's Name _____ **Spouse** _____

Patient's Date of Birth _____ **Marital Status** _____

Patient SS# _____ **Spouse SS#** _____

Patient's Home Address _____

_____

City State Zip Code County

Mailing Address _____

_____

City State Zip Code County

Cell Phone: _____

Home Phone: _____

Email Address: _____

*****If patient is a minor, please complete the following guardian / guarantor information*****

Name of Parent / Guardian / Guarantor _____

Date of Birth _____

Phone Number _____

SS# _____

Name of Parent / Guardian / Guarantor _____

Date of Birth _____

Phone Number _____

SS# _____

FAMILY STATUS

List all dependents you support [if you need additional space use reverse side]:

Name	**Age**	**Relationship**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT

Patient's employer: _____ Position _____

Contact _____ Phone # _____

If self-employed-name of business _____

Spouse's employer: _____ Position _____

Contact _____ Phone # _____

If self-employed-name of business _____

Contact _____ Phone # _____

Guardian/Guarantor employer _____ Position _____

Contact _____ Phone # _____

If self-employed-name of business _____

Most recent annual family income (Note 1): $ _____

***Note 1**: Eligibility determinations will be made based on family income, which shall be based on the gross income. For purposes of this policy, a patient's family unit shall include a) the patient's legal spouse, b) the patient's registered domestic partner, c) each parent having legal custody of the patient, and d) the patient's legal guardian, if applicable.*

COMMENTS: use reverse side as needed.

***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. Please provide proof for every identified source of income. **Examples of proof of income include:**

- Most recent W-2's
- Current pay stubs
- Bank Statements
- Last year's income tax return
- Written, signed statements from employers or others (letter of support) stating your current financial situation and circumstances if you have no proof of income
- Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance
- Forms approving or denying unemployment compensation; or written statements from employers or welfare agencies

Schedule 1

Bear Valley Community Healthcare District

Financial Assistance Evaluation Application

CURRENT MONTHLY INCOME

Gross pay from employment (before deductions) as reported on pay stub

Patient/Guardian	**$ _____**
Spouse	**$ _____**
Income from operating business	**$ _____**
Other income:	
Interest and dividends	**$ _____**
Income from real estate	**$ _____**
Income from investments	**$ _____**
Social Security	**$ _____**
Other [specify] _____	**$ _____**
Alimony/support payments	**$ _____**
Total monthly income	**$ _____**

MONTHLY EXPENSES

Rent/mortgage payment	**$ _____**
Food	**$ _____**
Utilities (electric, water, etc.)	**$ _____**
Automobile payment (s)	**$ _____**
Other transportation expense (gas, bus, etc.)	**$ _____**
Telephone (s)	**$ _____**
Insurance (home, automobile, life, etc.)	**$ _____**
Credit cards/other debt	**$ _____**
Other [specify] _____	**$ _____**
Total monthly expenses	**$ _____**

Net monthly income [monthly income less monthly expenses] **$ _____**

EXTRAORDINARY CIRCUMSTANCES

Please provide information for any unusual expenses or income or events such as previous unpaid medical bills, a recent bankruptcy, court judgments, or one-time earnings (bonuses). If you need additional space, you may write on the back of this page or attach a separate page.

Schedule 2

Bear Valley Community Healthcare District

Financial Assistance Disclosure Application

Charity Care/Financial Need Discount

Have you applied for Medi-Cal?	☐ Yes	☐ No
Are you under 21 years of age?	☐ Yes	☐ No
Are you 65 years of age or older?	☐ Yes	☐ No
Are you legally blind?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you unable to work because of a physical or mental illness or disability that is expected to last longer than one year?	☐ Yes	☐ No
Do you have a minor child under 21 years of age in your home?	☐ Yes	☐ No
Do you have Medicare?	☐ Yes	☐ No
Do you have Health Insurance?	☐ Yes	☐ No
If yes, please list below		
Do you live in a nursing home?	☐ Yes	☐ No
Are you a veteran or a dependent of a veteran?	☐ Yes	☐ No
Are you being treated as a victim of a crime?	☐ Yes	☐ No
Are you being treated for a Workers Comp injury?	☐ Yes	☐ No
List all sources of assistance available to the patient		
Medicare	☐ Yes	☐ No
Medi-Cal	☐ Yes	☐ No
Healthily Families/Kids	☐ Yes	☐ No
Healthily Kids	☐ Yes	☐ No
Other (explain below)	☐ Yes	☐ No
Commercial Insurance Coverage	☐ Yes	☐ No
Out-Of-Country Insurance, explain below coverage limitations	☐ Yes	☐ No

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COMMENTS: ***(Use reverse side as needed.)***

Schedule 3

Bear Valley Community Healthcare District
Financial Assistance Disclosure Application
Charity Care/Financial Need Discount

Requesting Charity Care/Financial Need Discount For: (Check all that apply)

- ☐ Total charges on patient bill(s) $_____
- ☐ Co-insurance/Co-payment $_____
- ☐ Deductible(s) $_____
- ☐ Other patient liabilities (non-covered items) $_____
- ☐ Medi-Cal Share of Cost $_____

If your insurance company is paying a portion of your bill, please complete the following and attach copies of the supporting receipts, invoices, bills, or other documentation.

Out-of-pocket expenses* incurred by you at Bear Valley within 12 month period of application:
$_____

Out-of-pocket expenses are all patient bill balances, co-insurance, co-payment, or deductibles incurred at Bear Valley by the patient.

Out-of-pocket medical expenses** paid by you or your family within 12-month period of _____ application: $_____

****Out-of-pocket medical expenses are any medical expenses paid by the patient or the patient's family, including expenses paid for physician services, hospital services, drugs, and any other medical services.***

I attest that the financial information I have provided is complete and accurate and I agree that Bear Valley may verify this information. I agree to notify Patient Financial Services of any changes in my financial circumstances and to provide upon request, insurance eligibility status.

I agree that Bear Valley may disclose the information contained on this application to any third party who may help fulfill my request for charity care or financial need discounts.

Patient's Signature _____

_____
Print Name

Date Signed _____

Representative for Patient Signature _____

_____
Print Name

Relationship _____

Date Signed _____

Bear Valley Community Healthcare District

Financial Assistance Disclosure Application

Charity Care/Financial Need Discount

Please visit the following web sites for further information on Insurance coverage and Financial Aid:

www.BVCHD.com

https://www.coveredca.com

Home | BenefitsCal. Together, we benefit.

https://www.va.gov

https://iehp.org/

www.Molina Healthcare.com

Home | Blue Shield of California (blueshieldca.com)

https://healthconsumer.org

https://www.consumerhealthalliance.org