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#:	_____	_____	_____
Relationship:	_____	_____	_____
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.

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

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 CHCC Staff

Finance Department Staff:

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

Director of Patient Accounting_____ Date_____

EVP Finance/CFO_____ 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 (ie 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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ELIGIBILITY CRITERIA for Financial Assistance Effective: March 15, 2022

(Subject to change yearly)

INCOME CRITERIA

The table below describes the percentage of charges paid when gross annual income is within the following poverty income guidelines, published by the Department of Health and Human Services (HHS).

Family Size	Patient pays 0% of charges <=200%	Patient pays 20% of charges >200<=225%	Patient pays 40% of charges >225<=250%	Patient pays 60% of charges >250<=275%	Patient pays 80% of charges >275<=300%	Patient pays 100% of charges >300<=500%
1	$27,180 or less	$27,181 to $30,578	$30,579 to $33,975	$33,976 to $37,373	$37,374 to $40,770	$40,771 or more
2	$36,620 or less	$36,621 to $41,198	$41,199 to $45,775	$45,776 to $50,353	$50,354 to $54,930	$54,931 or more
3	$46,060 or less	$46,061 to $51,818	$51,819 to $57,575	$57,576 to $63,333	$63,334 to $69,090	$69,091 or more
4	$55,500 or less	$55,501 to $62,438	$62,439 to $69,375	$69,376 to $76,313	$76,314 to $83,250	$83,251 or more
5	$64,940 or less	$64,941 to $73,058	$73,059 to $81,175	$81,176 to $89,293	$89,294 to $97,410	$97,411 or more
6	$74,380 or less	$74,381 to $83,678	$83,679 to $92,975	$92,976 to $102,273	$102,274 to $111,570	$111,571 or more
7	$83,820 or less	$83,821 to $94,298	$94,299 to $104,775	$104,776 to $115,253	$115,254 to $125,730	$125,731 or more
8	$93,260 or less	$93,261 to $104,918	$104,919 to $116,575	$116,576 to $128,233	$128,234 to $139,890	$139,891 or more
For families greater than 8 members, add amount below to the highest amount in the column for each additional family member:						
8 or more Add to columns	$9,440	$10,620	$11,800	$12,980	$14,160	

NOTE: A pregnant woman is counted as two family members.

ASSETS CRITERIA

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