Financial Assistance Policy - Plain Language Summary

Bay Area Hospital is committed to ensuring our patients get the hospital care they need regardless of ability to pay for that care. Providing health care to those who cannot afford to pay is part of our mission and state law requires hospitals to provide free and discounted care to eligible patients (the FA Discount). You may qualify for free or discounted care based on family size and income, even if you have health insurance.

If you think you may have trouble paying for your health care, please talk with us. When possible, we encourage you to ask for financial help before receiving medical treatment.

What is covered? For emergency and other appropriate hospital-based services at Bay Area Hospital, we provide financial assistance/charity care to eligible patients on a sliding fee scale basis, with discounts ranging from 25% to 100%. No patient eligible for financial assistance/charity care will be charged more than amounts generally billed to patients who have insurance.

How to apply: Any patient may apply to receive financial assistance/charity care by submitting an application and providing supporting documentation. If you have questions, need help, or would like to receive an application form or more information, please contact us:

- When you are checking in or checking out of the hospital;
- By telephone to the Patient Accounts Department at (541) 266-6098
- On our website at **www.bayareahospital.org/patient-resources/Financial-Assistance**
- In person at the Patient Accounts Department, Bay Area Hospital, 1988 Newmark Ave, Coos Bay, OR 97420
- To obtain documents via mail free of charge, please call or visit the Patient Accounts Department at (541) 266-6098

If English is Not Your First Language: Translated versions of the application form, financial assistance policy, and this summary, are available upon request, in English and Spanish.

Other Assistance:

Coverage assistance: You may be eligible for other government and community programs. We can help you learn whether these programs including Medicaid, can help cover your medical bills. We can help you apply for these programs.

Uninsured Discounts: Patients not eligible for the FA discount may be eligible for other discounts such as the Un-insured discount and the Prompt Pay discount. Please contact the Patient Accounts department for details.

Payment Plans: Any balance for amounts owed by you is due within 30 days. The balance can be paid in any of the following ways: Credit card, payment plan, cash, or check, or online bill pay. If you need a payment plan, please call the number on your billing statement.

Emergency care: Bay Area Hospital has a dedicated emergency department and provides care for emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act) without discrimination consistent with available capabilities, without regard to whether or not a patient has the ability to pay or is eligible for financial assistance.

Thank you for trusting us with your care.

Bay Area Hospital

Financial Assistance Application Form Instructions

This is an application for financial assistance at Bay Area Hospital.

The State of Oregon requires all hospitals to provide financial assistance to people and families who meet certain criteria income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance.

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

If you have questions or need help completing this application: Please contact the Patient Accounts Department at (541) 266-6098 for assistance in completing this application. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- ☐ **Provide us information about your family**
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- ☐ **Provide us information about your family's gross monthly income (income before taxes and deductions)**
- ☐ **Provide documentation for family income and declare assets**
- ☐ **Attach additional information if needed**
- ☐ **Sign and date the form**

Note: You do not have to provide a Social Security number to apply for financial assistance. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA".

Mail or fax completed application with all documentation to: Bay Area Hospital, 1775 Thompson Road, Coos Bay, OR 97420, attn. Patient Accounts Department, or fax to (541) 269-8517. Be sure to keep a copy for yourself.

To submit your completed application in person: Patient Accounts Department, (541) 266-6098.

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.

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

Bay Area Hospital

Financial Assistance - confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? □ **Yes** □ **No** *May be required to apply before being considered for financial assistance*

Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** □ **No**

Is the patient currently homeless? □ **Yes** □ **No**

Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 30 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify_____)	Birth Date		Patient Social Security Number (optional)
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Mailing Address _____ _____ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____

Employment status of person responsible for paying bill: □ **Employed** □ **Self-Employed** □ **Student** □ **Disabled** □ **Unemployed** (how long unemployed:_____) □ **Retired** □ **Other**(_____)

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. **FAMILY SIZE** _____ *Attach additional page if needed.*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
Work study programs (students) - Pension - Retirement account distributions - Other (*please explain*_____)

Bay Area Hospital

INCOME INFORMATION

***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. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income. You must also include 2 months of complete bank statements with your proof of income.

Examples of proof of income include:

- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSES

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ *(child support, loans, medications, other)*

ASSET INFORMATION

We use this information may be used if your income is above 101% of the Federal Poverty Guidelines.

Current checking account balance $_____	Does your family have these other assets? **Please check all that apply**
Current savings account balance $_____	□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s) □ Property (excluding primary residence) □ Own a business

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Bay Area Hospital may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date