Barton Financial Counselor
2170 South Avenue
South Lake Tahoe, CA 96150

530.539.6086 **TEL**
530.238.3226 **FAX**
*bartonhealth.org/financialassistance*

## How to Apply for Financial Assistance Program

Thank you for choosing Barton Health as your healthcare provider. We understand that medical bills can be burdensome and applying for assistance can be confusing. Barton offers different ways to help patients pay for their care by providing financial assistance, based on household income. **We may be able to help you with all or part of your financial responsibility, based on your eligibility.**

Patients who qualify for financial assistance will have:

- An annual family income that is less than or equal to 400% of the federal poverty level, as determined by guidelines published annually by the U.S. Department of Health and Human Services;
- Met with a Barton Financial Counselor to explore eligibility for other programs, such as: Workers' Comp, Medi-Cal, and Victims of Crime; and
- Completed a Financial Assistance Program application and provided supporting documentation to verify income.

In order to determine your eligibility for financial assistance, you will need to complete the Financial Assistance application and provide additional documents to process your eligibility, including:

- Copy of prior year's income tax return (Form 1040) for you and your spouse or domestic partner or a copy of two (2) most recent pay stubs for you and your spouse or domestic partner.

Your completed financial assistance application and supporting documents may be returned by email to financialassistance@bartonhealth.org, via fax to 530-238-3226, in person to the Financial Counselor located at the Admitting department within Barton Memorial Hospital and also by mail to:

Barton Financial Counselor
2170 South Avenue
South Lake Tahoe, CA 96150

Barton will make every effort to process your application promptly and determine your eligibility for financial assistance. Once your application has been reviewed, you will receive a letter to notify you of the outcome. If you have questions concerning Barton's Financial Assistance Program, need assistance completing the application, or would like to talk about additional options, please do not hesitate to contact a Barton Health Financial Counselor at 530.539.6086.

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# 2024 Federal Poverty Level Guidelines
# Eligibility Guide for Financial Assistance Program

## Eligibility Table

Using household income and size as calculated in the table below to identify eligibility for financial discount.

| Financial Assistance Level | | | 100% | 75% | 50% | 25% |
|---|---|---|---|---|---|---|
| | | 2024 Federal Poverty Income Level-Annual | 100% | 250 - 300% | 300 - 350% | 350 - 400% |
| Size of Family Unit | 1 | $15,060 | $15,060 - $37,649 | $37,650 - $45,180 | $45,180 - $52,710 | $52,710 - $60,240 |
| | 2 | $20,440 | $20,440 - $51,099 | $51,100 - $61,320 | $61,320 - $71,540 | $71,540 - $81,760 |
| | 3 | $25,820 | $25,820 - $64,549 | $64,550 - $77,460 | $77,460 - $90,370 | $90,370 - $103,280 |
| | 4 | $31,200 | $31,200 - $77,999 | $78,000 - $93,600 | $93,600 - $109,200 | $109,200 - $124,800 |
| | 5 | $36,580 | $36,580 - $91,449 | $91,450 - $109,740 | $109,740 - $128,030 | $128,030 - $146,320 |
| | 6 | $41,960 | $41,960 - $104,899 | $104,900 - $125,880 | $125,880 - $146,860 | $146,860 - $167,840 |
| | 7 | $47,340 | $47,340 - $118,349 | $118,350 - $142,020 | $142,020 - $165,690 | $165,690 - $189,360 |
| | 8 | $52,720 | $52,720 - $131,799 | $131,800 - $158,160 | $158,160 - $184,520 | $184,520 - $210,880 |

# BARTON HEALTHCARE SYSTEM FINANCIAL ASSISTANCE PROGRAM

## CONFIDENTIAL FINANCIAL STATEMENT AND FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____

Account Number(s): _____ Date of Service(s): _____

### Responsible Party*

Name _____

Address: _____

_____

Phone: _____

SSN/TIN: _____

Employer: _____

### Spouse or Domestic Partner

Name _____

Address: _____

_____

Phone: _____

SSN/TIN: _____

Employer: _____

### Marital Status (circle one):

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Unmarried ☐ Partnered

### Family Information:

Please list all persons living with you plus any children 21 or under, whether or not they live with you.

| | Name: | Age: | Relationship to you: |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ |

## Monthly Household Income

Gross monthly income from wages $ _____

Social Security $ _____

Unemployment Compensation $ _____

Child Support/Alimony $ _____

Other $ _____

**TOTAL INCOME: $ _____**

## Expenses

Monthly Home/Rental Pymnt: $ _____ Medical/Dental: $ _____

Medical Ins. Premium $ _____ Transportation: $ _____

Utilities/Home Phone: $ _____ Child Care/Tuition: $ _____

Food/Home/Personal Necessities $ _____ Other: _____ $ _____

Child Support/Alimony: $ _____

**TOTAL EXPENSES: $ _____**

Living Wage Calculation: $
*(For office use only)* _____

*By signing this form, I authorize Barton Health to verify any information. I understand that I may be required to provide proof of the information requested. Additionally, I certify that all the statements made on this application are true and complete to the best of my knowledge. Should it be determined that the information I provided is incomplete, any discount on my bill may be reversed, and payment in full may be expected of me.*

*If I receive payment from an insurance company, worker's compensation or any third party, I agree to inform the hospital of such payment. I understand that the hospital retains its right to collect the original, full billed charges should a third party provide full or partial payment for the hospital's services.*

Signature of Patient or Legal Guardian Date

Signature of Spouse or Domestic Partner Date

*This document is to be completed by the patient's legal guardians if the patient is a minor.

**Hospital Bill Complaint Program**

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

Contact us if you have any questions or concerns about billing or the collection process.