First Name | Last Name | Case # | Sit

748

Staff ID | Form Code | Service Date

Supervisor Initials

Financial Statement

Payment Plan/Uncompensated Services Application

Client Name: _____

Application Date: _____

Date(s) of Service: _____

Address: _____

_____

Telephone Number: _____ Date of Birth: _____

When client is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

Signature of Legal Representative: _____

Print Name: _____ Date of Signature: _____

Relationship to Client: _____

Dependents Living in Household: _____

_____

FEDERAL POVERTY GUIDELINES

From the Federal Register the Federal Poverty Guidelines effective July 1, 2023 are as follows:

SIZE OF FAMILY	100%	200%	CLIENT (Check Below)
1	$14,580	$29,160	☐
2	$19,720	$39,440	☐
3	$24,860	$49,720	☐
4	$30,000	$60,000	☐
5	$35,140	$70,280	☐
6	$40,280	$80,560	☐
7	$45,420	$90,840	☐
8	$50,560	$101,120	☐
9	$55,700	$111,400	☐
10	$60,840	$121,680	☐
For each additional member over 10 add…	$5,140	$10,280	☐

Client Name: _____ Case #: _____

FAMILY INCOME ** & SOURCE

	PATIENT	SPOUSE	TOTAL
MONTHLY SALARY(GROSS)	$0.00	$0.00	$ 0.00
UNEMPLOYMENT BENEFITS	$0.00	$0.00	$ 0.00
SOCIAL SECURITY BENEFITS	$0.00	$0.00	$ 0.00
INVESTMENTS	$0.00	$0.00	$ 0.00
WORKMAN'S COMPENSATION	$0.00	$0.00	$ 0.00
CHILD SUPPORT	$0.00	$0.00	$ 0.00
OTHER (ALIMONY, ETC.)	$0.00	$0.00	$ 0.00
TOTAL	$ 0.00	$ 0.00	$ 0.00

TOTAL FAMILY INCOME $ 0.00 (per above) (Documents conclusion on poverty)

TOTAL FAMILY MEMBERS _____

This information should be used to check the appropriate box on Page 1.

**** Family income is defined as income that is recognized by the IRS (as defined by the Care Connection form per APS.)**

Please provide one or more of the following information to verify the above determination:

- W-2 withholding statements for all employment during the relevent time period
- Check stubs for the past 30 days for all persons employed in the home
- Most recent income tax (IRS) tax forms (must be signed)
- Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance within the affected service period
- Forms approving or denying unemployment compensation: or
- Written statements from employers or welfare agencies (denial letters)

Client Name: _____ Case #: _____

CHARITY CARE DETERMINATION SHEET

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE THE BEHAVIORAL HEALTH CENTER TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

_____ _____
Signature of client making request Date

_____ _____
Signature of legal representative Date

DO NOT WRITE BELOW THIS LINE – FOR OFFICE PERSONNEL USE ONLY

This document was received and completed by:

_____ _____
Staff Signature/Title Date

_____ _____
Staff Signature (2nd Reviewer)/Title Date

Subsequent Reviews		
Revision No. _____ (if applicable)		
	Initial	Date
Review	_____	_____
Review	_____	_____
Review	_____	_____
Review	_____	_____
Review	_____	_____
Review	_____	_____

Our Charity Care Determination was based upon the following:

Financial Need:

1) Individual/Family Income (per Federal Poverty Level Section):
   Below Poverty: Yes ☐ No ☐

2) Judgment (justification form) and signed by client _____
   Below Poverty: Yes ☐ No ☐ Crisis ☐
   [Complete worksheet detailing why official documentation could not be obtained.]

Service Need:

3) BHHF Service Criteria Met thru APS (MNA submission)
   Yes ☒ No ☐

NOTE: Must have "yes' marked on both Financial and Service to be considered for Charity Care

Conclusion:

Charity Care – by BHHF Definition	☐	Target 4311.1	☐
Charity Care Other – by Non BHHF Definition	☐	Non Target 4311.2	☒
Does Not Qualify for Charity Care	☐		

**Crisis activity is exempt from completing all mandatory elements of a charity care application, however, this sheet must be completed and crisis documented.*

Client Name: _____ Case #: _____

STANDARDIZED JUSTIFICATION FORM

TO DOCUMENT STEPS TAKEN TO VALIDATE

CLIENT INCOME IS 200% OR BELOW OF POVERTY

(This form is to be completed if the documentation noted on page 2 cannot be obtained)

Document steps taken to prove income is 200% or below of poverty. (Client was not able to produce an audit trail per the required documents noted on page 2 of the application.)

Reason why official documentation could not be obtained.

Basis for conclusion.

Conclusion (Judgment)
Below poverty ☐ YES ☐ NO

Document completed by (Provider staff)

_____ _____

Staff Name Date