Patient Name: _____ DOB: _____ Date: _____

Permanent Address: _____ City: _____ ZIP: _____

State: _____ Hm Phone: _____ Wk Phone: _____

Mailing Address if Different:

Address: _____ City: _____

State: _____ ZIP: _____

Employer Name: _____ Employer Ph: _____

Employer Address: _____

1	Have you applied for financial aid or completed this form in the last 90 days?	☐ Yes	☐ No
2	Do you currently have any type of health insurance?	☐ Yes	☐ No
3	Was your provider visit a result of an accident at work?	☐ Yes	☐ No
4	Was your provider visit a result of an auto accident?	☐ Yes	☐ No

If you answered YES to ANY of the questions above, STOP. Contact the Business Office of the Baptist facility where services were received to discuss your account.

For the following table, please list the patient and all family members living in the same household as the patient. Family members are persons related by birth, marriage, or adoption. Include the relationship and age of all family members. Then, list the amount and source of each person's income. Income includes gross (pre-tax) wages, rental income, unemployment compensation, social security, retirement, disability benefits, public assistance, etc. Documentation supporting the income calculations must be submitted with this signed application.

Family Member (Name)	Relationship to Patient	Age	Source of Income or Employer Name	Last Three Months Pay Stubs	Income for 12 Months Tax Return
Total Family Members			Total Income		

Your application cannot be processed unless you provide <u>one</u> of the following documents to support <u>each source</u> of income listed above.

Pay stubs for the last three months
Income Tax return for the previous year
W2 Form for the previous year
Federal & State Assistance Documents
Legal documents/Child Support
Pension/retirement statements
Bank Statements (for SSA/Retirement deposits only)

Please return this application and the requested information to the Business Office of the Baptist facility where services were received.

I certify that the information provided is true and accurate to the best of my knowledge.

_____ _____

Signature of Patient, or Person Authorized to Sign for Patient **Relationship to Patient**

_____ **Place of Service** _____ **Hospital or** _____ **Physician**

Date

FOR PROVIDER USE ONLY

Account Number _____ Date of Service _____

BMHCC Provider _____

BAPTIST

Baptist Central Business Office
P.O. Box 745336, Atlanta GA 30384-5336
Fax # 901-226-0772
Email Address: fap@bmhcc.org

FINANCIAL APPLICATION

Form # 0101-44 (04/24)

▼ Patient Label ▼

RECFIN

RECEIPT OF FINANCIAL ASSISTANCE APPLICATION FORM

Baptist is committed to treating all patients equally, with dignity, respect and compassion. We provide medical services in anticipation of payments by patients and/or those financially responsible for the patient in exchange for the treatments rendered.

As a service to our community, Baptist offers financial assistance to our patients for emergency and/or medically necessary care. The amount of financial assistance is dependent upon the patient completing the Baptist Financial Assistance Application and turning in the financial information required for determining eligibility.

Patients may be eligible for up to a 100% discount from total charges, subject to the evaluation of the information provided. Failure to provide the requested information, including financial records will impact the amount of financial assistance each patient receives.

To determine your eligibility, please complete a Financial Assistance Application and submit all of the required personal and financial information to the Business Office in the facility where you received or are receiving care.

I acknowledge that I have received a copy of the Baptist Financial Assistance Application and Plain Language Summary of the Financial Assistance Policy.

Signature of Patient or Person Authorized to Sign for Patient	Relationship to Patient
Witness	Date

BAPTIST

RECEIPT OF FINANCIAL ASSISTANCE APPLICATION FORM

▼ Patient Label ▼

AUTHPA

BAPTIST

AUTHORIZATION FOR PATIENT ASSISTANCE PROGRAMS

Introduction:

Baptist, in furtherance of its mission to provide cost-effective health care, participates in programs with drug manufacturers wherein the manufacturers offer assistance in providing medications for hospitalized, low-income/non-insured patients who meet certain standards. The drug manufacturers often require personal, demographic, diagnostic, therapeutic, and financial information as part of the application process. Your signature may also be required on a separate application. We are requesting your permission to provide drug manufacturers the requested medical/financial information to facilitate your participation in the program. For your convenience, we are also requesting your permission to sign any additional program application forms as your agent.

Authorization:

I acknowledge that I have received a copy of Baptist's Notice of Privacy Practices. I understand that neither my treatment rights nor payment requirements are affected by my agreement or refusal to participate in a patient assistance program or whether I sign this authorization. Eligibility for state funded health benefits (i.e. Medicaid, TennCare, etc.) is not affected by signing this authorization.

I authorize Baptist to provide my personal, demographic, diagnostic, therapeutic, and/or financial information necessary to apply for drug manufacturer assistance programs. I understand that this may include the release of information about my HIV status and/or sexually transmitted diseases (STD). I further authorize Baptist to release personal, demographic, diagnostic, therapeutic, and/or financial information to drug manufacturers for my participation in a patient assistance program. I authorize Baptist to complete program applications on my behalf. I understand that after my information is released to the drug manufacturers, further use and disclosure of my information will be governed by the drug manufacturers' Notices of Privacy Practices. My information may no longer be governed by federal privacy laws. This authorization may be revoked at any time by contacting Baptist in writing as described in Baptist's Notice of Privacy Practices.

By signing this Authorization, I am requesting to participate in a Patient Assistance Program, which may cover the cost of drugs I need while in the hospital. I authorize Baptist to sign any and all forms and applications for the Patient Assistance Programs on my behalf.

Furthermore, by signing this authorization, I attest that the information I provide is true and accurate.

This authorization expires one year from the date it is signed.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Name

BAPTIST

AUTHORIZATION FOR PATIENT ASSISTANCE PROGRAMS

▼ Addressograph / Patient Label ▼

BAPTIST

Plain Language Summary
Hospital Financial Assistance Policy (FAP)

Baptist offers financial assistance to uninsured and underinsured patients for emergency or medically necessary care. The eligibility for uninsured financial assistance depends upon income eligibility criteria based on the Federal Poverty Income Guidelines. Discounts range from 50% to 100% on a sliding scale determined using the patient's family size and income.

No patient will be denied financial assistance because of their race, religion, national origin or any other basis which is prohibited by law. Baptist has implemented a Hospital Financial Assistance Policy (FAP) to benefit the communities we serve. It is the intent of this FAP to provide assistance to our patients in compliance with Internal Revenue Code Section 501(r) and all other applicable federal, state and local laws, rules and regulations.

Baptist Hospital FAP Overview:

Application: The process to determine if an uninsured patient qualifies begins when the patient submits a completed Financial Assistance Application. Applications are available in the Admissions, Emergency and Business Office Departments at all Baptist hospital facilities. Applications are also available by contacting a participating facility, by downloading online at www.baptistonline.org/, or requesting via email at FAP@BMHCC.org.

Application Period: Patients have 240 days from the date of their first bill to return their completed application and the required supporting financial documentation to the Business Office of the facility where that patient received medical services. Applications are processed and a determination letter sent to the patient within 30 days.

Minimum Self-Pay Discount: If an uninsured patient is unable or unwilling to provide the necessary documentation to complete a Hospital FAP evaluation, a minimum self-pay discount will be applied to all eligible charges on all applicable accounts. The amount of this minimum discount fluctuates by facility.

Amount Generally Billed (AGB): A Hospital FAP eligible patient will never be charged more than the AGB for emergency or other medically necessary care charged to patients who have insurance.

Non-Participating Providers: Some physicians/clinicians do not participate in Baptist's Hospital FAP. Please check the website for a list of participating providers.

Medically Underinsured: The FAP also contains a provision for insured patients with an out of pocket liability over a set amount in a single encounter.

Collection Activities: Baptist will make reasonable efforts to determine if a patient is eligible for a Hospital FAP discount before making any extraordinary collection attempts. Collection practices will be completed in accordance with the Baptist billing and collection guidelines. Collection attempts may be completed by the hospital or a designated agency. Non-payment will not be reported to a collection agency until a minimum 120 days after the first billing date.

Translations: Translations of all Baptist Hospital FAP documents are also available on the Baptist website and in the Business Offices at all Baptist hospitals. Assistance will be provided upon request for populations with limited English proficiency in accordance with federal regulations.

Patient Confidentiality: Information submitted for consideration under the Baptist Hospital FAP will be treated as protected health information under the Health Insurance Portability and Accountability Act.