

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 January 1, 2026 are as follows:

SIZE OF FAMILY	100%	200%	CLIENT (Check Below)
1	\$15,960	\$31,920	<input type="checkbox"/>
2	\$21,640	\$43,280	<input type="checkbox"/>
3	\$27,320	\$54,640	<input type="checkbox"/>
4	\$33,000	\$66,000	<input type="checkbox"/>
5	\$38,680	\$77,360	<input type="checkbox"/>
6	\$44,360	\$88,720	<input type="checkbox"/>
7	\$50,040	\$100,080	<input type="checkbox"/>
8	\$55,720	\$111,440	<input type="checkbox"/>
9	\$61,400	\$122,800	<input type="checkbox"/>
10	\$67,080	\$134,160	<input type="checkbox"/>
For each additional member over 10 add...	\$5,680	\$11,360	<input type="checkbox"/>

Client Name: _____

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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 relevant 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: _____

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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

Our Charity Care Determination was based upon the following:

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

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	<input type="checkbox"/>	Target 4311.1	<input type="checkbox"/>
Charity Care Other – by Non BHHF Definition	<input type="checkbox"/>	Non Target 4311.2	<input checked="" type="checkbox"/>
Does Not Qualify for Charity Care	<input type="checkbox"/>		

**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