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, 2024 are as follows:

| SIZE OF FAMILY | 100% | 200% | CLIENT (Check Below) |
|---|---|---|---|
| 1 | $15,060 | $30,120 | ☐ |
| 2 | $20,440 | $40,880 | ☐ |
| 3 | $25,820 | $51,640 | ☐ |
| 4 | $31,200 | $62,400 | ☐ |
| 5 | $36,580 | $73,160 | ☐ |
| 6 | $41,960 | $83,920 | ☐ |
| 7 | $47,340 | $94,680 | ☐ |
| 8 | $52,720 | $105,440 | ☐ |
| 9 | $58,100 | $116,200 | ☐ |
| 10 | $63,480 | $126,960 | ☐ |
| For each additional member over 10 add… | $5,380 | $10,760 | ☐ |

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