



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 be:

- Uninsured with an annual family income that is less than or equal to 400% of the Federal Poverty Level, or
- Insured with high out of pocket costs, and an annual family income that is less than or equal to 400% of the Federal Poverty Level

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 Federal Income Tax Return (Form 1040) for patient and spouse or domestic partner from the year the patient was first billed or 12 months prior to when the patient was first billed

--or--

- Recent pay stubs for patient and spouse or domestic partner from within the 6 months before or after the patient was first billed

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, or 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 the Barton Health Financial Counselor at 530.539.6086.

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.

2026 Federal Poverty Level Guidelines Eligibility Guide for Financial Assistance Program

Eligibility Table

The table below identifies income levels eligible for financial assistance:

Financial Assistance Level			100%	75%	50%	25%
		2026 Federal Poverty Income Level-Annual	0 – 249%	250 - 299%	300 - 349%	350 - 400%
Size of Family Unit	1	\$15,960	\$15,960- \$39,899	\$39,900- \$47,879	\$47,880- \$55,859	\$55,860- \$63,840
	2	\$21,640	\$21,640- \$54,099	\$54,100- \$64,919	\$64,920- \$75,739	\$75,740- \$86,560
	3	\$27,320	\$27,320- \$68,299	\$68,300- \$81,959	\$81,960- \$95,619	\$95,620- \$109,280
	4	\$33,000	\$33,000- \$82,499	\$82,500- \$98,999	\$99,000- \$115,499	\$115,500- \$132,000
	5	\$38,680	\$38,680- \$96,699	\$96,700- \$116,039	\$116,040- \$135,379	\$135,380- \$154,720
	6	\$44,360	\$44,360- \$110,899	\$110,900- \$133,079	\$133,080- \$155,259	\$155,260- \$177,440
	7	\$50,040	\$50,040- \$125,099	\$125,100- \$150,119	\$150,120- \$175,139	\$175,140- \$200,160
	8	\$55,720	\$55,720- \$139,299	\$139,300- \$167,159	\$167,160- \$195,019	\$195,020- \$222,880

Family is defined as:

- For persons 18 years of age and older, spouse, domestic partner, dependent children under 21 years of age, or any age if disabled, whether living at home or not, and
- For persons under 18 years of age or for a dependent child 18 to 20 years of age, parent, caretaker relatives, and other children under 21 years of age, or any age if disabled, of the parent or caretaker relative.

Barton Health Financial Assistance Application

CONFIDENTIAL FINANCIAL STATEMENT AND FINANCIAL ASSISTANCE APPLICATION

Patient Information

Patient Legal Name: _____

Date of Application (MM/DD/YYYY): _____

Barton Health Account Number(s): _____

Date(s) of Service (MM/DD/YYYY): _____

Responsible Party Information

Legal Name: _____

Permanent Mailing Address: _____

City: _____ State: ____ Zip: _____

Home/Cell Phone: _____ SSN: _____ - _____ - _____

Employer: _____ Work Phone: _____

Spouse/Domestic Partner Information

Legal Name: _____

Permanent Mailing Address: _____

City: _____ State: ____ Zip: _____

Home/Cell Phone: _____ SSN: _____ - _____ - _____

Employer: _____ Work Phone: _____

Marital Status

- 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.

	<u>Name</u>	<u>Age</u>	<u>Relationship to Patient</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Monthly Household Income

Gross Monthly Income from Wages (before Deductions) \$ _____
 Social Security: \$ _____
 Unemployment Compensation: \$ _____
 Child Support / Alimony: \$ _____
 Other: \$ _____
TOTAL MONTHLY INCOME \$ _____

Monthly Household Expenses

Monthly Mortgage or Rent Payment: \$ _____
 Medical Insurance Premium: \$ _____
 Medical / Dental Expenses (Not Including Insurance): \$ _____
 Child Care / Tuition: \$ _____
 Transportation (Car, Bus, Taxi): \$ _____
 Utilities - Electricity, Gas, Water, Telephone: \$ _____
 Food / Home / Personal Necessities: \$ _____
 Child Support / Alimony: \$ _____
 Other: \$ _____
TOTAL MONTHLY EXPENSES \$ _____
 Living Wage Calculation (for office use only) \$ _____

By signing this form, I authorize Barton Memorial Hospital 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, workers' 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.

Patient, Guardian or Responsible Party Signature: _____

Date (MM/DD/YYYY): _____ Time: _____

Spouse or Domestic Partner Signature: _____

Date (MM/DD/YYYY): _____ Time: _____

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