Notification of Approval/Denial for Financial Assistance

PACIFIC GROVE HOSPITAL

Date: _____

Guarantor Name: _____

Guarantor Address: _____

Guarantor City, State, Zip: _____

Patient Name: _____

Patient Account Number: _____

_____ Date of Service:

Dear Mr/Mrs _____,

We have carefully reviewed your application for financial assistance and have determined that your account:

( ) meets the facility's established guidelines for financial assistance

( ) meets the facility's established guidelines for financial assistance

pending outcome/resolution of your Medicaid application

Approved per diem or % of charges: $_____

Total approved discount amount: $_____

( ) does not meet the facility's established guidelines for financial

assistance Reason for denial:

____ monthly income exceeds qualifications

____ potential third party payor source through _____

____ application not complete

____ supporting documentation not adequate

If you have any questions, please call _____ at

_____.

Sincerely,

Facility Business Office Representative

Attachment BO-104 Notification of Approval/Denial

PACIFIC GROVE HOSPITAL FINANCIAL DISCLOSURE FORM

_____

Name of Patient/Guarantor Patient Account #

_____

Social Security Number Date of Birth

Employer _____ Phone _____

Gross monthly income $_____

Any additional Source of income (child support/alimony) $_____

Total Monthly Gross Household Income (Proof of income required)

$_____

Date last worked _____ Employment status _____ (FT, PT, Seasonal,

Retired, unemployed) Number of dependents including Self: _____ Marital Status

_____

Housing: Own _____ Rent _____ Monthly payment $_____

Please list any other financial information to be considered in determining your ability for payment:

_____

_____

Cobra eligible? Yes or No If yes, insurance company _____ premium _____

To receive healthcare at a reduced cost to you, you must cooperate fully with our need for accurate and detailed financial information, including the timely production of necessary documentation to support this disclosure. For patients applying only for discount payment, only recent paystubs or income tax returns are required for documentation. Completion of the Financial Disclosure Form does not guarantee that you will be eligible for a cost reduction in your healthcare.

Patients that only apply for discount payment may receive less financial assistance than what may be available under the charity care program.

I authorize representatives of Pacific Grove Hospital and its affiliates to verify the information on this form and to release any of my information for payment purposes. The information given above is true and complete. I agree to notify Pacific Grove Hospital of any changes in my financial situation. I further authorize Pacific Grove Hospital and its affiliates to review and inquire into my credit history, including using a Credit Bureau History Report, Employer W2 verification, and/or IRS verification.

Signed _____ Date _____

Witness _____ Date _____

PACIFIC GROVE HOSPITAL

Patient Responsibility Worksheet

Patient/Guar. Name _____ Acct No. _____

Admission Date _____

Is the patient covered by any of the following?

Medicare _____ Lifetime psych days available _____

Medicaid _____

Other Govt. _____
Assistance _____
Health Ins. _____

Please provide copies of any online verification completed for any of the above items.

A. Charge Per day or Per Diem Rate:
B. Estimated Length of Stay: _____
C. Estimated Total Charge/Rate (Line A x B) $0.00

D. Patient Responsibility

1. Deductible	$0.00
2. Admit Fee	$0.00
3. Co-Pay per day/session	$0.00
4. Co-insurance %	$0.00

E. Estimated Patient Liability

1. Estimated Total Charge/Rate (Item C above)	$0.00
2. Less Deductible/Admit Fee (D1 + D2 above)	$0.00
3. Difference (E1 minus E2)	$0.00
4. Estimated co-pay (D3 times B above)	$0.00
5. Estimated co-insurance (E3 times D4))	$0.00
6. Estimated patient liability for this stay	$0.00
7. Out of pocket maximum	

F. Balances Due from previous stays

Acct #_____	Balance	$0.00
Acct #_____	Balance	$0.00

Total Estimated Patient Liability	**$0.00**

Has the patient been hospitalized in the past 90 days? _____

If Yes, when and where? _____

_____

The above estimate was calculated using the information that we received from your insurance company. Your signature below acknowledges that you have been informed of the estimated amount that is your responsibility.

_____ Date _____
Patient or Guarantor

Witness

(Administrative Use Only)
Approval Signature:_____ Date _____