SAN JOSE BEHAVIORAL HEALTH FINANCIAL DISCLOSURE FORM

1. Name of Patient/Guarantor_____
2. Patient Account #_____
3. Social Security Number _____
4. Date of Birth _____
5. Employer _____
6. Phone_____
7. Gross monthly income $_____
    a. Any additional Source of income (child support/alimony) $_____
    b. Total Monthly Gross Household Income (Proof of income required) $_____
8. Date last worked _____Employment status _____(FT, PT, Seasonal, Retired, unemployed)
9. Number of dependents including Self: _____ Marital Status _____
10. Housing: Own _____Rent _____Monthly payment $_____
11. Please list any other financial information to be considered in determining your ability for payment: _____

12. Cobra eligible? Yes or No _____

a. 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 San Jose Behavioral Health 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 San Jose Behavioral Health of any changes in my financial situation. I further authorize San Jose Behavioral Health and its affiliates to review and inquire into my pay/income stubs and W-2.

Signed _____ Date _____

Witness _____ Date _____

SAN JOSE BEHAVIORAL HEALTH

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

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 _____

SAN JOSE BEHAVIORAL HEALTH

Notification of Approval/Denial for Financial Assistance

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 day or 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