Banner Health

# Banner Lassen Financial Assistance Program for Discount and Charity Care

## Summary of Financial Assistance Program

Banner Health offers Financial Assistance Programs, including Charity Care and Discounted Payments, to patients who are Uninsured, Underinsured and Medically Indigent. This policy applies to Banner hospitals and certain other BH entities. An Uninsured Patient means a patient without Third-Party Insurance and who is not enrolled in a government insurance program. Uninsured Patients are initially charged the Self-Pay Rate for Covered Services. An Underinsured Patient means a patient with Third-Party Insurance coverage, but with financial limitations or co-responsibility, including deductibles, co-payments, and co-insurance, has out-of-pocket expenses that exceed his/her financial abilities. A Medically Indigent Patient means a household with medical expenses where the portion for which the household is responsible exceeds 50% of the household's total income for that year. For the purposes of determining whether a household is a Medically Indigent Household, all medical expenses are included, including non-BH medical expenses.

**Eligibility Criteria** – Eligibility for charity care is based on household income if the patient's annual household income and household size is equal to or less than 200% of the Federal Poverty Level. Eligibility for discounted payment is based on household income if: (1) the patient's annual household income and household size is equal to or less than 400% of the Federal Poverty Level; or (2) medical expenses, including both Banner and non-Banner services, exceed 50% of their household income. The amount of assistance will be approved on a sliding scale depending on household income and all medical expenses.

Patients who qualify for BH Financial Assistance will not be charged more than HSC (§ 127405(d)) expected payment limit and AGB for Covered Services, which is based upon the average of the amounts that would have been paid to the Hospital by Medicare/Medi-Cal (and co-pays and deductibles) for the medically necessary services received if they were insured. Emergency care is always provided without requiring advance payment. For non-emergency services, a substantial deposit or payment arrangement may be required based on estimated charges. For a list of Banner's standard charges and shoppable services visit https://www.bannerhealth.com/patients/billing/pricing-resources/hospital-price-transparency and select your facility.If you are an Underinsured patient, you may qualify for BH Financial Assistance for Underinsured/Balance After Insurance discount. You will need to apply for consideration and meet both Hospital bill balance requirements stated in the Financial Assistance Policy and Federal Poverty Level guidelines.

If you qualify for BH Financial Assistance, you will in no case be charged more than Amounts Generally Billed for emergency services or other medically necessary services. In addition, you will never be required to make advance payment or other payment arrangements to receive emergency services. However, to receive non-emergent services, you will be required in most situations to make a substantial advance deposit or other payment arrangements based upon an estimate of the Amounts Generally Billed.

**Medi-Cal Presumptive Eligibility** – You may be eligible for a government-sponsored health benefit program. Medi-Cal's presumptive eligibility program provides qualified individuals with immediate access to temporary, no-cost Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage.

**Covered California** – You may be eligible for health care coverage under Covered California, which is the California health benefit exchange under the Affordable Care Act. Covered California is a free service that can connect Californians with health insurance potentially at a discount.



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A free copy of the hospital's financial assistance, billing, and collections policies, and the application forms, are available on the Banner Health website at BannerHealth.com. Spanish translations of this Summary, the Hospital's financial assistance and billing policies, and the applications forms are available on the Banner and Hospital websites and in the hospital's Admitting area. Copies are also available by mail by contacting Banner Patient Financial Services at (888) 264-2127. The Banner Patient Financial Services staff is available to answer questions and provide information about the Financial Assistance Programs, the application process, and nonprofit organizations and government agencies that can assist with these applications. Please contact (888) 264-2127 if you have further questions.

If you need help in another language, please call 888-264-2127 from 6:00 AM to 10:00 PM or visit the Banner Lassen Medical Center information desk located at 1800 Spring Ridge Drive, Susanville, CA 96130. Aids and services for people with disabilities, such as documents in braille or large print, audio, and other accessible electronic formats are also available. These services are free.

**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.

**Help Paying Your Bill** – There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

For a list of Banner's standard charges and shoppable services visit https://www.bannerhealth.com/patients/billing/pricingresources/hospital-price-transparency and select your facility.

The Banner Patient Financial Services staff is available to answer questions and provide information about the Financial Assistance Programs, the application process and nonprofit organizations and government agencies that can assist with these applications. Please contact (888) 264-2127 if you have further questions.

**DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD**

## Application for Financial Assistance Discount or Charity Care at Banner Lassen

**Instructions - Please fill in all fields, attach the required documentation, and send to**
Banner Health c/o PBM, PO Box 743711, Los Angeles, CA 90074-3711 or
BannerFAApplications@bannerhealth.com

**Proof of Income – required.** Acceptable documents include

- If currently employed, copies of 3 most recent payroll stubs for Patient, Applicant (if not patient), and Spouse/Partner, if they occurred within a 6-month period before or after the patient was first billed by the Hospital.
- If Self-employed or unemployed, a copy of income tax returns for the year in which the patient was first billed or 12 months prior to when the Patient was first billed by the Hospital.

**Applicant Information:**
Name: _____

Address: _____
Date of Birth: _____ Phone Number: _____ Email: _____
Employer: _____ Employment Status: _____
Length of Employment: _____ Unemployed Date or Length: _____

**Spouse or Partner Information:**
Name: _____
Address: _____
Date of Birth: _____ Phone Number: _____ Email: _____
Employer: _____ Employment Status: _____
Length of Employment: _____ Unemployed Date or Length: _____

**Family Member Information:** List family members in your household. A patient's "family" includes:

- For persons 18 years of age or older: a spouse; domestic partner, as defined in Section 297 of the California Family Code; and dependent children under 21 years of age, or any age if disabled, whether living at home or not.
- For persons under 18 years of age or for a dependent child 18 to 20 years of age: a parent, caretaker relatives, and other children under 21 years of age, or any age if disabled, of the parent or caretaker relative.

Please use another page if more than 5 Family Members.

1. Name: _____ Date of Birth: _____ Relationship: _____
2. Name: _____ Date of Birth: _____ Relationship: _____
3. Name: _____ Date of Birth: _____ Relationship: _____
4. Name: _____ Date of Birth: _____ Relationship: _____
5. Name: _____ Date of Birth: _____ Relationship: _____

**Financial Details:**
Income 1 Description: _____ Monthly Amount: _____
Income 2 Description: _____ Monthly Amount: _____

**Medical Liabilities:** Please list type of debt (i.e., doctor, hospital, imaging, DME, homecare, ambulance, etc).

1. Type: _____ Unpaid Balance: _____ Monthly Payment: _____
2. Type: _____ Unpaid Balance: _____ Monthly Payment: _____
3. Type: _____ Unpaid Balance: _____ Monthly Payment: _____
4. Type: _____ Unpaid Balance: _____ Monthly Payment: _____
5. Type: _____ Unpaid Balance: _____ Monthly Payment: _____

**Declaration and Signature**

Banner Health

I declare that I would like to participate in Banner Health's financial assistance program and understand all disclosed personal information is for the sole purpose of determining my eligibility. Banner Health will keep this secure and confidential. This Application will initiate the Patient for consideration for both Charity Care and Discounted Payments. Please note that Patients that only apply for Discounted Payments may receive less financial assistance than what may be available to the patient under the Charity Care program.

By signing below, I attest that the information I have provided is accurate to the best of my knowledge. It has been explained to me and I agree as a condition of my qualification for financial assistance from Banner Health, should I qualify and receive assistance, any third- party funding I receive or become eligible to receive, may be considered and recovered by Banner Health to address and offset the financial assistance discount provided to me, pursuant to Cal. Health & Safety Code § 3045.1 et seq. California's health care lien statute, or applicable statutes, may be considered and recovered by Banner Health to address and offset the financial assistance discount provided to me.

Responsible Party Signature: _____ Date and Time: _____
Printed Name: _____

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