Bothwell™
Regional Health Center

FINANCIAL APPLICATION

Please complete this financial application and include income and other supporting documentation as appropriate. **This documentation is required in order to process your application.** If the application and all required supplements are not received by the due date below, your application may not be considered.

ACCOUNT(S)

DATE SENT **DATE DUE**

INFORMATION

Patient Name	SSN-OPTIONAL	DOB	MARITAL STATUS S M D W	
GUARANTOR NAME	SSN-OPTIONAL	DOB	RELATIONSHIP TO PT.	PHONE
SPOUSE NAME	SSN-OPTIONAL	DOB	PHONE	
STREET ADDRESS	CITY		STATE	ZIP
PREVIOUS EMPLOYER (PATIENT OR GUARANTOR)	LAST DATE EMPLOYED		HOUSEHOLD SIZE ADULTS _____ CHILDREN _____	
CURRENT EMPLOYER (PATIENT OR GUARANTOR)	PHONE	CURRENT EMPLOYER (SPOUSE)	PHONE	
ADDRESS	CITY / STATE / ZIP	ADDRESS	CITY / STATE / ZIP	
POSITION OR TITLE	LENGTH OF EMPLOYMENT	POSITION OR TITLE	LENGTH OF EMPLOYMENT	
GROSS INCOME. ☐ WKLY. ☐ ☐ ☐		GROSS INCOME: ☐ ☐ ☐ ☐ MNTLY.		

PATIENT'S OR GUARANTOR'S MONTHLY INCOME		SPOUSE'S, MONTHLY INCOME	
WAGES	SOCIAL SECURITY INCOME	WAGES	SSI
PENSION	RENTAL INCOME	PENSION	RENTAL INCOME
ALIMONYICHILD SUPPORT	OTHER (INCL. FOOD STAMPS/TANF)	ALIMONY/CHILD SUPPORT	OTHER (INCL. FOOD STAMPS/TANF)

TOTAL MONTHLY INCOME	TOTAL MONTHLY EXPENSES	DIFFERENCE

PATIENT AGREEMENT

The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The undersigned authorizes the release of necessary medical and financial information to obtain third party coverage and/or to obtain replacement pharmaceuticals from appropriate drug company programs on their behalf. The original or a copy of this application will be retained by Bothwell Regional Health Center, even if the financial assistance is not granted. Falsification of information on this application is grounds for disapproval. I understand that Bothwell Regional Health Center may request a credit bureau report in the process of evaluating my application for financial assistance.

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF RESPONSIBLE PARTY OR SPOUSE _____ DATE _____

REQUIRED SUPPLEMENTAL DOCUMENTATION

When submitting this application, please also provide one [or more, when applicable] of the following documents as verification *of* household income:

- Copy of IRS Form 1040 and all applicable Schedules (C, E, F, etc.) from most recent tax year
- Copy of W-2 from most recent tax year for each working adult in the household
- Copy of Social Security Benefit Verification Letter from most recent year for each person receiving Social Security benefits
- Statement of weekly unemployment benefits
- Copies of paystubs from most recent three months for each working adult in the household

Please note that, when available, the most recent federal tax return is always the preferred means *of* income verification.

ADDITIONAL CONSIDERATIONS

This application is only valid for services performed and charges incurred at Bothwell Regional Health Center and BRHC Clinics.

Once we receive your documentation, we will review your application for full or partial financial assistance. If you do not need financial assistance or do not qualify, but still can not pay off your account balance within BRHC's pre-determined payment guidelines, we will consider this application for our extended payment program.

If approved, your application will be valid for one (1) year for charges incurred as a result of medically necessary and/or urgent visits, and we will consider additional BRHC accounts as subject to such approval for financial assistance during that period of time. If you are currently subject to a payment plan, we will re-evaluate your payment plan upon addition of other charges in order to ensure that payments remain appropriate in relation to both the agreement and the balance.

A Patient Financial Services Representative will notify you of the approval or disapproval of this application in writing. All of your information is kept confidential according to the strict protective guidelines of Bothwell Regional Health Center.

PAYMENT PLAN GUIDELINES

Payments must be a minimum of $50 every month, with a maximum allowance of thirty-six (36) months to pay the account in full. Please note that, if a payment is not received each month and no prior arrangement is made, the account may be considered delinquent and subject to further collection action.