Financial Assistance Application

In accordance with Baptist Health Care Financial Assistance Policy, patients may apply for assistance to financially resolve current medical bills incurred by a Baptist Health Care employed physician practice and/or hospital. A patient is approved for assistance based on the documented financial situation of the applying individual and their household, and the medical eligibility criteria outlined in the financial assistance policy.

PATIENT INFORMATION:

Patient name: _____ Date of Birth: _____

Address: _____ Contact Phone: _____

City: _____ State: _____ Zip: _____

Patient's primary care physician:_____

Is the patient the same as the person responsible for the bill (guarantor)? Yes_____ No_____

Is the patient covered by any insurance? *(If yes, complete the INSURANCE INFORMATION)* Yes_____ No_____

If no, is the patient eligible for coverage by their employer, spouse or parent's employer? Yes_____ No_____

If no, was insurance lost due to a life-changing event (job loss, marriage, divorce, or children no longer covered on parent's insurance)? Yes_____ No_____

If any of below is yes, provide appropriate information/communication:

Are services the result of a workplace or auto accident? Yes_____ No_____

Are you involved in any legal action/litigation? Yes_____ No_____

Are you eligible for COBRA benefits? Yes_____ No_____

Are you currently pending disability? Yes_____ No_____

Have you been denied for Medicaid or Food Stamps? Yes_____ No_____

Are you currently in bankruptcy proceedings? Yes_____ No_____

Are you self-employed? Yes_____ No_____

INSURANCE INFORMATION:

Insured Name: _____ Relationship to patient:_____

Insurance Policy Number:_____ Group Number:_____

Is the insurance policy through an employer? Yes __ No __. If yes, Employer Name: _____

Patient's employer:_____ Employer phone:_____

If patient is unemployed, last date of employment:_____

GUARANTOR HOUSEHOLD INFORMATION *(list all those living in your household, their age, relationships to Guarantor and employer)*

Legal Name	Age	Relationship to patient	Source of income

INCOME: *(please provide information on the income of all the household members)*

Source of Income	Payee	Monthly gross amount
Earned Income (paychecks, self-employment, etc.)		
Rental property/unearned income (alimony, child support, etc.)		
Social Security (Government payments/assistance, i.e., SSD, SSR)		
Unemployment benefits		
Other retirement/pensions etc.		
TOTAL INCOME:		

One of the following documents must be provided when submitting a financial assistance application:

Documentation of income may include most recent paycheck statement showing the current YTD earnings, or written verification of annual wages from employer, proof of public welfare, unemployment benefits award document, unearned monthly income deposit evidence (bank statement), or other governmental agencies written statement. Individual income tax form 1040 from the most recent calendar year maybe requested. Liquid assets may be evaluated and documentation of any liquid asset maybe requested.

Statement of understanding and agreement: The information I am providing is true and accurate to the best of my knowledge. I will apply and assist in the application process for any governmental assistance (Medicare, Medicaid, and Affordable Health Care Act). I only utilize Baptist Health Care Financial Assistance as a means of last resort. If any information I provide proves to be untrue, Baptist Health Care may reevaluate my financial assistance status and take what action is deemed appropriate.

Signature of Patient **Date**

Signature of Guarantor (if different than patient) **Date**

Team Member Signature **Date**

Record Request: Authorization to Use and Disclose Protected Health Information ("PHI")

This authorization shall apply to all of the following entities: Baptist Health Care, Inc., Jay Hospital, Inc., Baptist Medical Group, LLC, Baptist Urgent Care, LLC.

Patient's Name	Date of Birth	Medical Record #

Patient's Address	City	State	Zip

Phone #	E-mail Address

By signing this form, I authorize the release of PHI (i.e., medical records) as follows:

FROM the doctor, office or facility written below :	**TO the facility / person written below :**
Baptist Health Care, Inc.	☐ **Check here if same as patient** BHC Patient Financial Services
Hospital, Clinic, person or organization	Hospital, Clinic, person or organization
Attn:	Attn: **(for Substance Use Disorder records- name of PERSON is required)**
Address 123 Baptist Way, Pensacola, FL 32503	Address 700 E. Gregory Street, Pensacola, FL 32502
Phone Fax	Phone Fax

The following PHI may be released *(check boxes below)*:

☐ General Abstract (Face Sheet, Discharge, Summary, History/Physical, Operative Note, Consult, Pathology Reports)	☐ Physical/Occupational/ Speech Therapy	☐ Discharge Summary	☐ Behavioral Health
		☐ Medication List	☐ Genetic Testing
☐ History and Physical	☐ Radiology Reports	☐ UB-04/CMS 1500 Claim	☐ HIV/AIDS test result
☐ Consultations	☐ Radiology Images	☐ Itemized Bill	☐ **Substance Use Disorder - Describe how much and what kind of information may be disclosed below:**
☐ Emergency Room Record	☐ Lab/Pathology Reports	☐ Other:	
☐ Operative Report(s)	☐ Immunizations		
☐ Clinic/Office Notes – Physician Name:			

I further authorize the release of the following information which may be included in the PHI:

Are there specific dates needed? _____ **Dates**

Purpose of this request?	☐ Insurance Claim ☐ Legal Purposes ☐ At the Request of the Patient ☐ Medical Treatment – Physician Name:_____ ☐ Other:_____
Format of Records?	☐ Pick Up ☐ E-mail ☐ Fax ☐ Disc $6.50 ☐ Paper - *Mailed *If mailing, current postage rates apply

Please mail, email or fax completed form to:

Baptist Health Care
Financial Assistance
P.O. Box 17106
Pensacola, FL 32522

Email: financialassistance@bhcpns.org
Fax: 850.908.6938
Phone: 448.227.3600

This authorization allows any and all of the providers listed above to use and disclose certain PHI, which includes medical records, as I have directed. **I understand that:**

- My Substance Use Disorder records are protected under federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- I have a right to request a list of disclosures of my medical information, if requested in writing.
- I have a right to revoke this authorization at any time by providing written notice to BHC Request of Information, P.O. Box 17804, Pensacola, FL 32522-17804. I understand that the revocation will not apply to information that has already been released in response to this authorization or if the authorization was obtained as a condition of obtaining insurance coverage where the law provides my insurer with the right to contest a claim under my policy.
- Except for Substance Use Disorder and HIV (AIDS) records, once my PHI is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws.
- I understand that if I refuse to sign this authorization, my treatment, payment, enrollment or eligibility for benefits will not be affected.
- I will be provided a copy of this authorization.
- This authorization expires on: _____. (If blank, expiration is 90 days after signature.)

_____ _____

Signature of patient/patient representative **Date**

Complete the section below only if the person requesting records is not the patient:

Name of Representative	Relationship to Patient	Legal Authority
Representative's Address & Phone Number	Verification of Identity (Internal use only)	Verification of Authority (Internal use only)