Banner Health

BUOD NG MGA PROGRAMA PARA SA PINANSYAL NA TULONG AT LAHAT NG OSPITAL NA PAGMAMAY-ARI AT PINAPATAKBO NG BANNER HEALTH (BH)

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AT ALL HOSPITALS OWNED AND OPERATED BY BANNER HEALTH (BH)

Nag-aalok ang Banner Health ng mga Programa sa Pinansyal na Tulong sa mga pasyenteng Walang Insurance, Kulang ang Insurance, at Walang Pambayad sa Medikal. Ang polisiyang ito ay nalalapat lamang sa mga ospital ng Banner at sa ilang iba pang entidad ng BH. Ang isang Pasyenteng Walang Insurance ay isang pasyenteng walang Third-Party Insurance at hindi nakatala sa isang programa sa insurance ng pamahalaan. Ang mga Pasyenteng Walang Insurance ay sinisingil ng Self-Pay Rate sa umpisa para sa mga Covered na Serbisyo. Ang isang Pasyenteng Kulang ang Insurance ay isang pasyenteng may coverage ng Third-Party Insurance, ngunit may mga pinansyal na limitasyon o co-responsibility, kabilang ang mga deductible, co-payment, at co-insurance, may mga gastusin mula sa sariling bulsa na higit sa kanyang kakayahang pinansyal. Ang isang Walang Pambayad sa Medikal na Pasyente ay isang sambahayan na may mga medikal na gastusing natamo ng nakaraang 12 buwan, kung saan ang bahagi kung saan ang sambahayan ay may pananagutan ay lampas sa 50% ng kabuuang kita ng sambahayan para sa taong iyon. Para sa mga layunin ng pagtukoy kung ang isang sambahayan ay isang Sambahayang Walang Pambayad sa Medikal, isinasama ang lahat ng medikal na gastusin, kabilang ang mga gastusin na hindi para sa BH.

Kung isa kang pasyente na Walang Insurance, maaari kang magkwalipika para sa may diskwentong rate kung hindi mo natutugunan ang mga kwalipikasyon para sa Programa sa Pinansyal na Tulong batay sa mga patnubay sa Pederal na Antas ng Kahirapan (Federal Poverty Level guidelines). Ang pagkwalipika para sa may diskwentong pangangalaga ay nangangahulugan na ikaw ay masisingil nang 1.25 x AGB, Amounts Generally Billed (Mga Halagang Karaniwang Sinisingil), na batay sa average ng mga halagang binayaran sana sa Ospital ng mga pribadong insurer sa kalusugan at Medicare (at mga co-pay at deductible) para sa mga medikal na kinakailangang serbisyong natatanggap mo kung naka-insure ka.

Kung isa kang pasyente na Walang Insurance, magkakwalipika ka para sa Pinansyal na Tulong ng BH (1) kung mayroon kang taunang kita ng sambahayan at laki ng sambahayan na katumbas sa o mas mababa sa 400% ng Pederal na Antas ng Kahirapan at wala ng iba pang asset para bayaran ang buong mga singil ng Ospital at, (2) kung hiniling na gawin ng Ospital, mag-aaplay ka para sa Medicaid/AHCCCS, ganap na makikipagtulungan sa proseso ng pag-aplay at pagtukoy, o hindi makatwirang makukumpleto ang proseso ng aplikasyon, at tinanggihan ng coverage ng Medicaid/AHCCCS.

Kung isa kang pasyente na Kulang ang Insurance, maaari kang magkwalipika para sa Pinansyal na Tulong ng BH para diskwento para sa sa mga Kulang ang Insurance/Balanse Pagkatapos ng Insurance. Kailangan mong mag-aplay para sa pagsasaalang-alang at matugunan ang parehong mga kinakailangan ng balanse sa bill ng Ospital na nakasaad sa Patakaran sa Pinansyal na Tulong at mga patnubay sa Pederal na Antas ng Kahirapan.

Kung nagkwalipika ka para sa Pinansyal na Tulong ng BH, hindi ka sisingilin sa anumang kaso ng higit sa mga Amounts Generally Billed (Halagang Karaniwang Sinisingil) para sa mga serbisyong pang-emerhensya o iba pang mga medikal na kinakailangang serbisyo. Bilang karagdagan, hindi ka kailanman aatasan na magsagawa ng maagang pagbayad o iba pang mga kaayusan sa pagbabayad para makatanggap ng mga pang-emerhensyang serbisyo. Gayunpaman, upang makatanggap ng mga serbisyong hindi pang-emerhensya, kakailanganin kang magsagawa ng malaking paunang deposito o iba pang mga kaayusan sa pagbabayad batay sa pagtataya ng Amounts Generally Billed.

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Banner Health

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AT ALL HOSPITALS OWNED AND OPERATED BY BANNER HEALTH (BH)

Banner Health offers Financial Assistance Programs to Uninsured, Underinsured and Medically Indigent patients. 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 incurred during the previous 12 months, 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.

If you are an Uninsured patient, you may qualify for a discounted rate if you do not meet the qualifications for the Financial Assistance Program based on Federal Poverty Level guidelines. Qualification for the discounted care means, you will be charged 1.25 x AGB (Amounts Generally Billed,) which is based upon the average of the amounts that would have been paid to the Hospital by private health insurers and Medicare (and co-pays and deductibles) for the medically necessary services you receive if you had been insured.

If you are an Uninsured patient, you will qualify for BH Financial Assistance (1) if you have an annual household income and household size that is equal to or less than 400% of the Federal Poverty Level and lack other assets to pay the Hospital's full charges and, (2) if requested to do so by the Hospital, you apply for Medicaid/AHCCCS, fully cooperate in the application and determination process, or are unable to reasonably complete the application process, and are denied Medicaid/AHCCCS coverage.

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.

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Banner Health

BUOD NG MGA PROGRAMA PARA SA PINANSYAL NA TULONG AT LAHAT NG OSPITAL NA PAGMAMAY-ARI AT PINAPATAKBO NG BANNER HEALTH (BH)

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AT ALL HOSPITALS OWNED AND OPERATED BY BANNER HEALTH (BH)

Isang libreng kopya ng patakaran sa pinansyal na tulong ng ospital, ng patakaran sa pagsingil at pagkolekta, at ng mga application form ay available sa website ng Banner Health sa Bannerhealth.com. Ang pagsasalin sa wikang Espanyol ng Buod na ito, ng mga patakaran ng Ospital sa pinansyal na tulong at pagsingil, at mga application form ay available sa mga website ng Banner at Ospital at sa Admitting area ng ospital. Maaari din ipadala sa koreo ang mga kopya sa pamamagitan ng pagtawag sa Banner Patient Financial Services sa (888) 264-2127. Handang sumagot ng mga katanungan ang mga kawani ng Banner Patient Financial Services at magbigay ng impormasyon tungkol sa mga Programa sa Pinansyal na Tulong, sa proseso ng pag-aplay at mga nonprofit organization at ahensya ng gobyerno na makakatulong sa mga aplikasyong ito. Mangyaring tawagan ang (888) 264-2127 kung may higit ka pang katanungan.

Banner Patient Financial Services
PO Box 743711, Los Angeles, CA 90074-3711
BannerFAApplications@bannerhealth.com

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Banner Health

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AT ALL HOSPITALS OWNED AND OPERATED BY BANNER HEALTH (BH)

A free copy of the hospital's financial assistance policy, the billing and collections policy, and the application forms are available on the Banner Health website at Bannerhealth.com. Spanish translation 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.

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Banner Health

BUOD NG MGA PROGRAMA SA PINANSYAL NA TULONG AT APLIKASYON

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AND APPLICATION

Ibalik sa: Banner Health c/o PBM PO Box 743711, Los Angeles, CA 90074-3711 BannerFAApplications@bannerhealth.com	Kasalukuyang Petsa: Pangalan ng Pasyente: Petsa ng Kapanganakan: Pasilidad: Petsa ng Serbisyo:

Mga Tagubilin: Kumpletuhin ang aplikasyon at isama ang sumusunod na dokumentasyon at ibalik sa address o email sa itaas.

**Hindi naaangkop para sa mga lokasyon sa NHSC kabilang ang: Fallon, NV, Fernley, NV, Susanville, CA, Payson Primary Care, AZ, Payson OBGYN, AZ, Maricopa, AZ, Torrington, WY, at Wheatland, WY.

- Katibayan ng kita. Kabilang sa mga katanggap-tanggap na mga dokumento ang:
  - Kung kasalukuyang may trabaho, mga kopya ng huling tatlong (3) pinakakamakailang magkakasunod na payroll stub (pasyente, guarantor at asawa)
  - Kung self-employed, kopya ng Federal tax form Schedule C o iba pang katibayan ng kita at mga gastusin
  - Kung retirado at/o tumatanggap ng Social Security, kopya ng SSA 1099 form o sulat ng gantimpala**
  - Kung walang trabaho, kopya ng iyong federal income tax return ng nakaraang taon, sulat ng gantimpala para sa walang trabaho, o sulat ng pagdeklara sa sarili ng kita.**
  - Pagtukoy ng tulong ng Estado o gobyerno (Medicaid/AHCCCS)**
  - Kung hiniling, mga kopya ng mga medikal na bill na hindi sa Banner**

Impormasyon ng Aplikante

Pangalan ng Aplikante/Guarantor:_____ Numero ng Social Security:**_____

Address:_____

Petsa ng Kapanganakan:_____

Numero ng Telepono:_____

Tagapag-empleyo:_____ Katayuan sa Pag-eempleyo:_____

Tagal ng Pag-eempleyo:_____ Petsa na Walang Trabaho/Tagal:_____

Impormasyon ng Asawa o Partner

Pangalan:_____

Tagapag-empleyo:_____ Katayuan sa Pag-eempleyo:_____

Petsa ng Kapanganakan:_____

Numero ng Telepono:_____

Impormasyon ng Umaasa at/o Laki ng Sambahayan

Pangalan:	Relasyon:	Petsa ng Kapanganakan: (mm/dd/yyyy)
1		
2		
3		
4		
5		
6		

Paglalarawan ng Kita:	Buwanang Halaga:
1	$
2	$

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Banner Health

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AND APPLICATION

Return to: Banner Health c/o PBM PO Box 743711, Los Angeles, CA 90074-3711 BannerFAApplications@bannerhealth.com	Current Date: Patient Name: Birth Date: Facility: Date of Svc:

Instructions: Complete application and include the following documentation and return to address or email above.

**Not applicable for NHSC locations including: Fallon, NV, Fernley, NV, Susanville, CA, Payson Primary Care, AZ, Payson OBGYN, AZ , Maricopa, AZ, Torrington, WY and Wheatland, WY.

- Proof of income. Acceptable documents include:
  - If currently employed, copies of last three (3) most recent consecutive payroll stubs (patient, guarantor and spouse)
  - If self-employed, a copy of Federal tax form Schedule C or other proof of income and expenses
  - If retired and/or receiving Social Security, a copy of SSA 1099 form or reward letter**
  - If Unemployed, a copy of your prior year's federal income tax return, unemployment reward letter or self-declaration of income letter.**
  - Determination of State or government assistance (Medicaid/AHCCCS)**
  - If requested, copies of non-Banner medical bills**

Applicant Information

Applicant/Guarantor Name:_____ Social Security Number:** _____

Address: _____

Birth Date: _____

Phone Number: _____

Employer: _____ Employment Status: _____

Length of Employment: _____ Unemployed Date/Length: _____

Spouse or Partner Information

Name: _____

Employer: _____ Employment Status: _____

Birth Date: _____

Phone Number: _____

Dependent and/or Household Size Information

Name:	Relationship:	Birthdate: (mm/dd/yyyy)
1.		
2.		
3.		
4.		
5.		
6.		

Income Description:	Monthly Amount:
1.	$
2.	$

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SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AND APPLICATION

Ibalik sa: Banner Health c/o PBM PO Box 743711, Los Angeles, CA 90074-3711 BannerFAApplications@bannerhealth.com	Kasalukuyang Petsa: Pangalan ng Pasyente: Petsa ng Kapanganakan: Pasilidad: Petsa ng Serbisyo:

Medikal na Impormasyon		
Uri ng Utang / Kanino:	**Hindi Bayad na Balanse:**	**Buwanang Bayad:**
1. (Doktor)	$	$
2. (Ospital)	$	$
3. (Imaging)	$	$
4. (DME/Pangangalaga sa Tahanan)	$	$
5. (Ambulansya)	$	$
6.	$	$

Gusto kong makilahok sa programa sa pinansyal na tulong ng Banner Health at nauunawaan na ang lahat ng isiniwalat na personal na impormasyon ay para sa tanging layunin ng pagtukoy ng aking pagiging karapat-dapat. Pananatilihin ito ng Banner Health na ligtas at kumpidensyal.

Ang impormasyong ibinigay ko ay tumpak sa abot ng aking kaalaman. Ipinaliwanag ito sa akin at sumasang-ayon ako bilang kondisyon ng aking pagiging kwalipikado para sa tulong pinansyal mula sa Banner Health, kung ako ay maging kwalipikado at makatanggap ng tulong, ang anumang pagpopondo ng third-party na matatanggap ko o maging karapat-dapat na matanggap, alinsunod sa ARS Sec. 33-931, et seq., batas ng Arizona sa health

care lien (legal na karapatan sa ari-arian ng iba bilang panagot sa pagkakautang), o mga naaangkop na batas, ay maaaring isaalang-alang at mabawi ng Banner Health upang tugunan at ma-offset ang diskwentong tulong pinansyal na ibinigay sa akin.

Lagda ng Responsableng Partido: **Petsa/Oras:**_____

I-print ang Pangalan:_____

Lagda ng Asawa o Partner:_____ **Petsa/Oras:**_____

I-print ang Pangalan:_____

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Return to: Banner Health c/o PBM PO Box 743711, Los Angeles, CA 90074-3711 BannerFAApplications@bannerhealth.com	Current Date: Patient Name: Birth Date: Facility: Date of Svc:

Medical Information		
Type of Debt / to Whom:	**Unpaid Balance:**	**Monthly Payment:**
1. (Doctor)	$	$
2. (Hospital)	$	$
3. (Imaging)	$	$
4. (DME/Home Care)	$	$
5. (Ambulance)	$	$
6.	$	$

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.

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 qualifying for financial assistance from Banner Health, should I qualify and receive assistance, any third-party funding I receive or become eligible to receive, pursuant to ARS Sec. 33-931, et seq., Arizona'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/Time:** _____

Print Name:_____

Spouse or Partner Signature: _____ **Date/Time:** _____

Print Name: _____

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