Banner Health

Banner Lassen Financial Assistance Program for Discount and Charity Care

Summary of Financial Assistance Program

Banner Health offers Financial Assistance Programs to patients who are Uninsured, Underinsured and Medically Indigent. Financial Assistance is available at Banner hospitals and certain other BH entities. Uninsured Patients have no third-party or government insurance and are charged the self-pay rate for covered services. Uninsured Patients are initially charged the Self-Pay Rate for Covered Services. Underinsured Patients have insurance but face financial hardship due to high deductibles, co-pays, or co-insurance. Medically Indigent Patients have medical expenses, including both Banner and non-Banner services, that exceed 50% of their household income.

Banner Patients qualify for financial assistance 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.

Underinsured patients may qualify for BH Financial Assistance - Discount for Underinsured/Balance After Insurance. Patients need to apply for consideration and meet both Hospital bill balance requirements stated in the Financial Assistance Policy and Federal Poverty Level guidelines.

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.

Free copies of Banner Health's financial assistance, billing, and collections policies—as well as application forms—are available in Spanish and English at BannerHealth.com. You can also request copies by mail or get help by calling Banner Patient Financial Services at (888) 264-2127, where staff can assist with applications and connect you to additional resources.

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. Visit HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

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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
BannerFAAApplications@bannerhealth.com

Proof of Income – required. Acceptable documents include:

A. 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.
B. 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:

A. 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, whether living at home or not.
B. For persons under 18 years of age: a parent, caretaker relatives, and other children under 21 years of age 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: _____

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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

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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