Financial Assistance Plain Language Summary

Baptist Health Care (BHC) provides free care to eligible patients who receive emergency or other medically necessary care from our hospital facilities and our providers. Financial Assistance is only available for eligible services billed by BHC. Covered facilities include Baptist Hospital, Jay Hospital, and Gulf Breeze Hospital as well as applicable providers.

**Assistance offered:**

Generally, a patient will be eligible for assistance if their family income is at or below 300% of Federal Poverty Guidelines (FPG). Hardship cases will be reviewed for possible qualification.

**How to Apply:**

Free copies of the BHC Financial Assistance Policy and the Financial Assistance Application are available several ways:

- At all BHC registration desks (including facility and provider locations)
- By calling Customer Service at 850-908-2000
- Via email request to financialassistance@bhcpns.org
- On BHC website at ebaptisthealthcare.org/patientfinancialresources/

Assistance will be provided in completing applications if needed. Complete applications should be mailed to:

Patient Financial Services - BHC
PO Box 17106
Pensacola, FL 32522

Or email to financialassistance@bhcpns.org

**Translations:**

The Financial Assistance Application, our Financial Assistance Policy and this Plain Language Summary are also available in Spanish at the locations noted above.

**For Help or Questions:**

Call Customer Service at 850-908-2000
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)

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Age</th>
<th>Relationship to patient</th>
<th>Source of income</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
### INCOME: (please provide information on the income of all the household members)

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Payee</th>
<th>Monthly gross amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned Income (paychecks, self-employment, etc.)</td>
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<td></td>
</tr>
<tr>
<td>Rental property/unearned income (alimony, child support, etc.)</td>
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<tr>
<td>Social Security (Government payments/assistance, i.e., SSD, SSR)</td>
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<tr>
<td>Unemployment benefits</td>
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<tr>
<td>Other retirement/pensions, etc.</td>
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</tbody>
</table>

**TOTAL INCOME:**

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**One of the following documents must be provided when submitting 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 maybe 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 prior to submission** | **Date**
Record Request: Authorization to Use and Disclose Protected Health Information ("PHI")

This authorization shall apply to all of the following entities: Baptist Hospital, Inc., Jay Hospital, Inc., Langhorne Cardiology Consultants, Inc., Baptist Medical Group, LLC, Baptist Physician Group, LLC, Baptist Physician Associates, LLC, Baptist Urgent Care, LLC, Andrews Institute Rehabilitation, LLC.

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Date of Birth</th>
<th>Medical Record #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Phone #</td>
<td>E-mail Address</td>
<td></td>
</tr>
</tbody>
</table>

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

**FROM the doctor, office or facility written below:**

- Baptist Health Care
- Hospital, Clinic, person or organization
- Attn:__________
- Address: 1000 West Moreno Street, Pensacola, FL 32501-7500
- Phone: ________
- Fax: ________

**TO the facility / person written below:**

- Baptist Health Care
- Hospital, Clinic, person or organization
- Attn: ________
- Address: 100 West Garden Street, Pensacola, FL 32502
- 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
- Radiology Reports
- Radiology Images
- UB-04/CMS 1500 Claim
- HIV/AIDS test result
- Consultations
- Lab/Pathology Reports
- Itemized Bill
- Substance Use Disorder - Describe how much and what kind of information may be disclosed below:
- Emergency Room Record
- Operative Report(s)
- Immunizations
- Other:

**Are there specific dates needed?**

<table>
<thead>
<tr>
<th>Dates</th>
</tr>
</thead>
</table>

**Purpose of this request?**

- Insurance Claim
- Legal Purposes
- 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
- P.O. Box 17804
- Pensacola, FL 32522
- Phone: 850.908.7119
- Email: BHROI@bhcpons.org
- Fax: 850.908.2124

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:

- 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**

<table>
<thead>
<tr>
<th>Date</th>
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Complete the section below only if the person requesting records is not the patient:

<table>
<thead>
<tr>
<th>Name of Representative</th>
<th>Relationship to Patient</th>
<th>Legal Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representative’s Address &amp; Phone Number</td>
<td>Verification of Identity (Internal use only)</td>
<td>Verification of Authority (Internal use only)</td>
</tr>
</tbody>
</table>