Ely-Bloomenson Community Hospital

328 West Conan Street • Ely, MN 55731-1198

PHONE: 218-365-8761, 218-365-8776 FAX: 218-365-8079

What is the ELY BLOOMENSON COMMUNITY HOSPITAL FINANCIAL ASSISTANCE PROGRAM?

Ely Bloomenson Community Hospital offers Financial Assistance to our patients who are uninsured and to our patients who have insurance but have a policy that leaves them with substantial out–of-pocket expenses so they are unable to manage their medical bills.

Ely Bloomenson Community Hospital Financial Assistance Program (FAP) provides an uninsured discount on bills for medically necessary care. The Financial Assistance Programs also provides a full or partial discount if you apply for Charity Care and are approved. The Charity Care discount is based on the FPG Income guidelines attached.

What are uninsured patients charged for care in the FAP?

They are charged the same as the amounts generally billed to insured patients for the same services. Uninsured patients receive an automatic uninsured discount that is in compliance with the Attorney General Agreement.

What services are covered under our FAP?

All Medical providers with privileges at EBCH are covered under our FAP. e.g. Medical doctors, NPs CRNAs who have privileges at our facility. A list of names can be provided upon request.

What does not qualify?

You will not receive help from Charity Care if:

- Your balance at EBCH is less than $500.
- You are involved in a Workers Comp, Auto or any other third party liability claim. You may apply for this program after the case settles.
- You are applying for disability. You may apply after the Disability Board decides your case.
- Services are from our Ely Community Pharmacy.
- Services from our Home Health.

How do I sign up for Charity Care?

- Fill out and return the application for Charity Care
- Send all copies requested. Read the directions carefully to see what copies you need to send.

Depending on your income, you may need to apply for medical assistance or for Minnesota Care (MN residents) for future medical treatment. Someone in our office can guide you regarding this. There are income guideline and asset guidelines to determine who can receive help from our Charity Care Program. There are also some limits as to how many times you can apply. The program may cover current and outstanding bills up to 24 months prior to the applying for charity care and may remain in effect for 3 months after the date we receive your application. Check with our office to find out when you can apply again.

How can I get more information?

Contact the Business Office 218-365-8761 or 218-365-8776.

Ely Bloomenson Community Hospital Charity Care

How to fill out your application
You will need to send some papers with your application:

1. **Have you applied for Medical Assistance?**
   If you applied and were denied, send a copy of the denial letter.
   If you have not applied call the Health & Human Services Department for the county you live in. Ask if you meet the guidelines to apply for Medical Assistance.

2. **Section A: Income**
   Send copies of your paycheck stubs showing your gross income for the last 3 months. Also send a copy of last year's Federal Tax Return (including Schedules D, E and F, if applicable) along with your application. If you are self-employed, send a copy of last year's Federal Tax Return along with your schedule C. If you have no job or income, you must show proof of how you pay rent, property taxes, utilities and how you buy food. If you are homeless, you must send a statement from a homeless shelter.
   Send information about the income of every adult living in your home. Include paycheck stubs or statement from their employer and last year's Federal Tax Return. Need documentation of child support, foster care, interest income, social security, disability payments, unemployment income and pensions. Please send a letter from the county if you receive any cash, food or other help from the county.

3. **Section B: Assets**
   Property: Send copies of your property tax statement. It must show the fair market value of your home and all other property you own or rent. Send a copy of your most recent mortgage statement on any property you own. Also, list your monthly payments.
   Cars & Other Property: Please list all cars, trucks, all recreational vehicles including but not limited to motorcycles, snowmobiles, atv's in your household. List the make, year, estimated value and monthly payment on the application. Also include proof of your owing balance from financial institution.
   Banking Information: Send copies of your bank statement for the last three months. The statements must show deposits, withdrawals and balances of your checking and savings account. Do not send deposits receipts. We can only accept statement copies.

Assets include:

- Savings and checking accounts
- IRA's and retirement accounts
- Recreational vehicles or cars not used to get to your job
- Real estate that is not your home
- Any other valuable property
- You might qualify for help paying your medical bills if your assets are less than $20,000 for one person and $40,000 for two or more.

Ely Bloomenson Community Hospital Charity Care
APPLICATION

Be sure you complete the entire application:

- Answer all questions on the application.
- Attach copies to the forms needed to show your income and assets.
- Sign & date the application.

GUARANTOR INFORMATION

Name (Guarantor): _____

Patient Name: _____

Address: _____

Home Phone: _____ Date of Birth: _____

Circle one: Married Single Widowed Divorced

Employer: _____

Occupation: _____

Address: _____ Employer's phone #: _____

Spouse's Employer: _____

Occupation: _____

Address: _____ Employer's phone #: _____

HOUSEHOLD INFORMATION

List the name, date of birth, and relationship of every person living at your address.
If a household member is over 18, please tell if this person is a fulltime student and give the name of the school enrolled.

NAME	DOB	RELATIONSHIP	EMPLOYER OR SCHOOL	FT STUDENT

Use separate sheet if need more room

Ely Bloomenson Community Hospital Charity Care
INSURANCE INFORMATION

Name of Health Care Coverage

_____

Provide copy of insurance card
(Group, Private, Medical Assistance, Medicare, Vets, etc)

Have you applied for medical assistance? Yes No Date: _____
If Yes, attach copy of denial letter.

A. INCOME INFORMATION
Please list all household income (wages, retirement pensions, interest income, unemployment benefits, workers compensation benefits, TANF payments, social security, child support, foster care, rental income, etc.) Attach copies of your paycheck stubs showing your **earnings for the last three (3) months**. Also attach a copy of your last year's tax return.

SOURCE	MONTHLY AMOUNT

If you are self-employed, please also attach a copy of your schedule C along with a complete tax return.

Use separate sheet if need more room

Ely Bloomenson Community Hospital Charity Care

B. ASSET INFORMATION

Please give as much detail as possible

PROPERTY

Other: Please list all land or property, such as lake property, land, property held on contract for deed, etc.

DESCRIPTION	OWN or RENT	IF OWN, HOW MANY YEARS	ESTIMATED VALUE	MONTHLY PAYMENT

Please attach a copy of your recent mortgage and property tax statements.

Use separate sheet if need more room

VEHICLES/RECREATIONAL

Please list all AUTO'S (cars, trucks), all recreational vehicles including but not limited to camper, boat, motorcycles, snowmobiles, atv's in your household.

AUTO or RECREATIONAL	YEAR	MAKE	VALUE	MONTHLY PAYMENT

Include proof of your owing balances from financial institution

Use separate sheet if need more room

BANKING INFORMATION

Please list all savings and checking accounts. Attach a copy of your three most recent statements showing all transactions for each account. We do not accept teller receipts; we only accept copies of your statements.

OTHER INVESTMENTS

Please list annuities, IRA's, 401K's, 403Bs, CDs, stocks, bonds, life insurance policies trust funds, mutual funds, etc.

TYPE OF ACCOUNT	BANKING OR FINANCIAL NAME	BALANCE	CASH VALUE	AUTHORIZATION TO RELEASE INFORMATION TO EBCH

Include proof of your owing balances from financial institution and cash value of other investments

Use separate sheet if need more room

Ely-Bloomenson Community Hospital

328 W Conan St, Ely, MN 55731

The Ely-Bloomenson Community Hospital will provide 100% uncompensated health care for those individuals (families) with incomes that fall at 100% of the federal poverty guideline and will provide uncompensated health care at a prorated rate to individuals (families) with incomes that fall within the levels below:

PRORATED CHARITY CARE SCHEDULE

Based on 2017 FPG

Family size	Annual Income			Prorated Reduction
1	0	to	11,880	100%
1	11,880	to	13,068	75%
1	13,068	to	14,375	50%
1	14,375	to	15,800	25%
1	15,800	to	over	None

Family size	Annual Income			Prorated Reduction
2	0	to	16,020	100%
2	16,020	to	17,622	75%
2	17,622	to	19,384	50%
2	19,384	to	21,307	25%
2	21,307	to	over	None

Family size	Annual Income			Prorated Reduction
3	0	to	20,160	100%
3	20,160	to	22,176	75%
3	22,176	to	24,394	50%
3	24,394	to	26,813	25%
3	26,813	to	over	None

Family size	Annual Income			Prorated Reduction
4	0	to	24,300	100%
4	24,300	to	26,730	75%
4	26,730	to	29,403	50%
4	29,403	to	32,319	25%
4	32,319	to	over	None

Family size	Annual Income			Prorated Reduction
5	0	to	28,440	100%
5	28,440	to	31,284	75%
5	31,284	to	34,412	50%
5	34,412	to	37,825	25%
5	37,825	to	over	None

Ely Bloomenson Community Hospital Charity Care

Please answer all questions and sign this form.

If you leave questions blank or do not include the forms or your signature, your requests will be denied. We cannot process an incomplete application. Please include all requested information to avoid delay.

I certify that this information is true and correct to the best of my knowledge. I give my permission to release the above information to Ely-Bloomenson Community Hospital. I authorize Ely-Bloomenson Community Hospital to verify any information on this application.

_____ _____

Signature Date

RETURN COMPLETED FORM TO:

EBCH
ATTN: Business Office
328 West Conan Street
Ely MN 55731

The application will be returned to you if it is not complete or if you do not send necessary copies requested.

If you need help filling out the application, please call our office. We can help you.