BATTLE MOUNTAIN GENERAL HOSPITAL
AND NURSING HOME
BATTLE MOUNTAIN CLINIC

COMMUNITY CARE PROGRAM

Guarantor/Financially Responsible Party Name: _____

Guarantor's Social Security #: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Family Size: _____ Patient Name: _____
(Adults/children living at your address supported by guarantor)

*DOCUMENTATION IS REQUIRED ON ALL * ITEMS*

1. GROSS FAMILY MONTHLY INCOME: Please indicate all sources of income
   - A. Patient/Guarantor* $_____
   - B. Spouse* $_____
   - C. Other Income* $_____ *TOTAL* _____

2. ASSETS:
   - A. Checking* $_____
   - B. Savings* $_____
   - C. Other* $_____ *TOTAL*_____

3. MONTHLY EXPENSES: Please indicate your average monthly expenses for the following items:
   - A. Food $_____
   - B. Utilities* $_____
   - C. Auto/Gas* $_____
   - D. Telephone* $_____
   - E. Child Care* $_____
   - F. Rent/Mortgage* $_____
   - G. Insurance* $_____
   - H. Other* $_____ *TOTAL*_____

*NET INCOME: (*Section 1+2 minus 3) _____

4. OTHER DOCUMENTS TO SUPPORT FINANCIAL NEED:
   - A. *COPY OF MEDICAID DENIAL* - IF APPLICABLE*
   - B. Most Recent Tax Return*
   - C. Past 3 Months Pay Stubs*
   - D. Other*

I affirm that the above information true and correct to the best of my knowledge. I hereby give permission to Battle Mountain General Hospital to verify employment, wages, assets, and liabilities as necessary to process this application for the Community Care Program. I understand all information will remain confidential.

_____ _____
Signature of Person Making Request *Date*

Developed 8/2005 by ES/la

BATTLE MOUNTAIN GENERAL HOSPITAL
535 S. Humboldt Street
Battle Mountain, NV 89820

SUBJECT: **COMMUNITY CARE PROGRAM**

SCOPE: **Financial Management**

POLICY:

Battle Mountain General Hospital and Nursing Home and Battle Mountain Clinic (BMGH) provide health care to all patients, regardless of race, religion or national origin. BMGH offers the Community Care Program to eligible patients who meet financial guidelines to qualify for an adjustment to charges.

PROCEDURE:

Community Care coverage will be retroactive for three months prior to the receipt of the completed application by the Patient Financial Services Department. Applicants approved for sliding fee payments will be eligible from the date of qualifying determination. Completed application includes:

- Financial statement, signed and dated
- Three months pay stubs from current employer
- Most recent tax return
- Any other documentation to support financial need

On receipt of completed application a decision will be made within five (5) working days. Applicants will be notified of the decision. Applicants may request a review of denial or partial denial within thirty (30) days of receipt of the notice. Applications will be maintained for seven years in a secured area pending future audits.

Approved applicants will only be valid for three months. An updated application must be made for continued coverage.

Once approval has been granted all applicable accounts will be adjusted using the Community Care Program adjustment scale, as follows:

INCOME ADJUSTMENT SCALE

% GOVERNEMENT LEVEL	YOU PAY:
Lowest Government Level	0% Billed Charges
10 % Over	10% of Billed Charges
20% Over	20% of Billed Charges
30% Over	30% of Billed Charges
40% Over	40% of Billed Charges
50% Over	50% of Billed Charges
60% Over	60% of Billed Charges
70% Over	70% of Billed Charges
80% Over	80% of Billed Charges
90% Over	90% of Billed Charges
100% Over	100% of Billed Charges