Date

Dear

Bonner General Health recognizes healthcare bills are often unexpected and can sometimes create financial hardship. In accordance with our mission to provide excellence in healthcare close to home, the **BGH Cares program** provides eligible individuals with assistance in paying their hospital bills. If you wish to apply for the **BGH Cares program**, please complete the enclosed application.

ALL DOCUMENTATION MUST BE ATTACHED FOR FULL CONSIDERATION
Please contact our office if you have questions regarding what is needed (208) 265-1158

- Please provide the previous two months income verification for all adults in the household: pay stubs, unemployment verification, profit/loss summary if self-employed, social security, disability letter, retirement, etc.

- For balances greater than $1,000.00, along with the income verification listed above please include a copy of your tax return including all schedules, 1099's and W-2 forms for the most recent year. If you do not file taxes or receive W2's, please state this in the additional information box on the back of application.

Please complete and sign the application **within 14 days of the date of this letter**. Our decision will be based on the information you provide in the application and supporting documentation.

Please mail to:

PATIENT FINANCIAL ADVOCATE
BONNER GENERAL HEALTH
520 N 3RD AVE
SANDPOINT, ID 83864-1507

If you have any questions about the **BGH Cares program** or would like to set up an appointment to meet with a financial advocate, please feel free to call our office at (208) 265-1158.

Sincerely,

Patient Financial Advocate

I have accounts at: ☐Bonner General Health ☐ Bonner General Immediate Care ☐ Sandpoint Women's Health
☐ Bonner General Behavioral Health ☐ Bonner General Orthopedics ☐ Bonner General ENT

1. ***Patient Information***

Patient Name		***Date of Birth***
Address:	***City, State, Zip:***	***Phone Number:***
Status of Head of Household (circle one): ***Single Married Separated Widowed Divorced*** ***Living with Significant Other: Yes No***	***Total Number of People in Household:***	***Length of Residence:***

2. If patient is a minor or a dependent, please list responsible party here:

Name: Date of Birth: Relationship to Patient: .

3. Other Individuals in Household:

Name	***Date of Birth***	***Name***	***Date of Birth***

4. ***Employment Information:***

Patient or Guarantor:	***Other Adult in Household:***
Employer:	Employer:
Job Title:	Job Title:
Pay rate: Monthly Gross:	Pay rate: Monthly Gross:

5. ***Include income for yourself, spouse and dependents. (Types include Business Income, Public Assistance, Social Security, Unemployment/Workers Comp, Child Support Payments, VA benefits, Rental Income, Alimony, Interest, and Dividends)***

Other Income Source and Amount	**Current Total Family Monthly Income**	**Total Family Income Last 12 Months**

***If expenses are split, please fill out both columns. If expenses are shared only fill out first column*.**

6. Monthly Expenses (not applicable for sliding scale consideration)

		Other Adult
Please circle one: Rent or Mortgage	***$***	***$***
Utilities (phone/cell, heat, electricity, propane, water/sewer/trash ,cable)	***$***	***$***
Auto payments/Gas	***$***	***$***
Auto/Life/Medical/Dental Insurance Premiums	***$***	***$***
Food (unless on food stamps, then only non-food items)	***$***	***$***
Loans and/or Credit Card Payments	***$***	***$***
Prescriptions and Monthly Medical Payments to other providers	***$***	***$***
Other:	***$***	***$***

Total Monthly Expenses	**$**	**$**

7.

Have you applied for Medicaid or any other State/County Assistance? (Check one)	*YES*	*NO*
If yes, approximate date of application	*Name and Telephone # of Caseworker, if applicable*	

8. Additional information pertinent to application:

- *Please provide any additional information you feel may assist us as we are evaluating your application.*

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Please submit the requested documentation listed on the cover letter

CERTIFICATION:

1. **I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.**
2. **I will apply for any and all assistance that may be available to help pay this bill and agree to be compliant with all agencies I apply to.**
3. **I understand the information submitted is subject to verification. Therefore I grant permission to authorize agents of Bonner General Health to verify any information necessary to process my application**

Signature (Guarantor/Patient)	**Date**
Signature (Other Adult in Household)	**Date**