

**Notification of Approval/Denial for Financial Assistance**  
San Jose Behavioral Health

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Date: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_

Guarantor Address: \_\_\_\_\_

Guarantor City, State, Zip: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Account Number: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Dear Mr/Mrs \_\_\_\_\_,

We have carefully reviewed your application for financial assistance and have determined that your account:

( ) meets the facility's established guidelines for financial assistance

( ) meets the facility's established guidelines for financial assistance pending outcome/resolution of your Medicaid application

Approved per day or diem or % of charges: \$\_\_\_\_\_

Total approved discount amount: \$\_\_\_\_\_

( ) does not meet the facility's established guidelines for financial assistance

Reason for denial:

\_\_\_\_ monthly income exceeds qualifications

\_\_\_\_ potential third party payor source through \_\_\_\_\_

\_\_\_\_ application not complete

\_\_\_\_ supporting documentation not adequate

If you have any questions, please call \_\_\_\_\_ at

\_\_\_\_\_.

Sincerely,

Facility Business Office Representative

SAN JOSE BEHAVIORAL HEALTH FINANCIAL DISCLOSURE FORM

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Name of Patient/Guarantor

Patient Account #

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Social Security Number

Date of Birth

Employer \_\_\_\_\_

Phone \_\_\_\_\_

Gross monthly income \$ \_\_\_\_\_

Any additional Source of income (child support/alimony) \$ \_\_\_\_\_

Total Monthly Gross Household Income (Proof of income required) \$ \_\_\_\_\_

Date last worked \_\_\_\_\_ Employment status \_\_\_\_\_ (FT, PT, Seasonal, Retired,  
unemployed)

Number of dependents including Self: \_\_\_\_\_ Marital Status \_\_\_\_\_

Housing: Own \_\_\_\_\_ Rent \_\_\_\_\_ Monthly payment \$ \_\_\_\_\_

Please list any other financial information to be considered in determining your ability for  
payment:

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Cobra eligible? Yes or No      If yes, insurance company \_\_\_\_\_ premium  
\_\_\_\_\_

To receive healthcare at a reduced cost to you, you must cooperate fully with our need for accurate and detailed financial information, including the timely production of necessary documentation to support this disclosure. For patients applying only for discount payment, only recent paystubs or income tax returns are required for documentation. Completion of the Financial Disclosure Form does not guarantee that you will be eligible for a cost reduction in your healthcare.

Patients that only apply for discount payment may receive less financial assistance than what may be available under the charity care program.

I authorize representatives of San Jose Behavioral Health and its affiliates to verify the information on this form and to release any of my information for payment purposes. The information given above is true and complete. I agree to notify San Jose Behavioral Health of any changes in my financial situation. I further authorize San Jose Behavioral Health and its affiliates to review and inquire into my credit history, including using a Credit Bureau History Report, Employer W2 verification, and/or IRS verification.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**SAN JOSE BEHAVIORAL HEALTH**

**Patient Responsibility Worksheet**

Patient/Guar. Name \_\_\_\_\_

Acct No. \_\_\_\_\_

Admission Date \_\_\_\_\_

Is the patient covered by any of the following?

Medicare \_\_\_\_\_ Lifetime psych days available \_\_\_\_\_

Medicaid \_\_\_\_\_

Other Govt. \_\_\_\_\_

Assistance \_\_\_\_\_

Health Ins. \_\_\_\_\_

**Please provide copies of any online verification completed for any of the above items.**

A. Charge Per day or Per Diem Rate:

B. Estimated Length of Stay: \_\_\_\_\_

C. Estimated Total Charge/Rate (Line A x B) \$0.00

**D. Patient Responsibility**

1. Deductible \$0.00

2. Admit Fee \$0.00

3. Co-Pay per day/session \$0.00

4. Co-insurance % \$0.00

**E. Estimated Patient Liability**

1. Estimated Total Charge/Rate (Item C above)	\$0.00
2. Less Deductible/Admit Fee (D1 + D2 above)	<u>\$0.00</u>
3. Difference (E1 minus E2)	\$0.00
4. Estimated co-pay (D3 times B above)	\$0.00
5. Estimated co-insurance (E3 times D4 )	<u>\$0.00</u>
<b>6. Estimated patient liability for this stay</b>	\$0.00
7. Out of pocket maximum	

**F. Balances Due from previous stays**

Acct # _____	Balance	<u>\$0.00</u>
Acct # _____	Balance	\$0.00

<b>Total Estimated Patient Liability</b>	<b>\$0.00</b>
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Has the patient been hospitalized in the past 90 days? \_\_\_\_\_

If Yes, when and where?

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The above estimate was calculated using the information that we received from your insurance company. Your signature below acknowledges that you have been informed of the estimated amount that is your responsibility.

\_\_\_\_\_ Date \_\_\_\_\_  
Patient or Guarantor

Witness

(Administrative Use Only)

Approval Signature: \_\_\_\_\_ Date \_\_\_\_\_