BLUE STAR IMAGING

FINANCIAL ASSISTANCE | APPLICATION

Patient Name: (Last, First, MI) SSN# PID#

Patient Home Address Street City/State Zip Code

____/____/____ Date of Birth (Mon/Day/Year)

____-____-____ Telephone Number

MARITAL STATUS:

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

If Married, Spouse's Name: _____

EMPLOYER INFORMATION:

Patient Employed? ☐ Yes ☐ No

Patient's Employer: _____

Spouse Employed? ☐ Yes ☐ No

Spouses Employer: _____

INCOME: Please provide the income for each of the following person(s)in your household, where applicable:

Patient: ☐ Full Time ☐ Part Time -Total Hours/Week= _____ $ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year ☐ N/A

Spouse: ☐ Full Time ☐ Part Time -Total Hours/Week= _____ $ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year ☐ N/A

COMPLETE THIS INCOME SECTION ONLY IF THE PATIENT IS A MINOR (18 YEARS & UNDER)

Patient's Mother or Legal Guardian:

☐ Full Time ☐ Part Time -Total Hours/Week= _____ $ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year ☐ N/A

Patient's Father or Legal Guardian:

☐ Full Time ☐ Part Time -Total Hours/Week= _____ $ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year ☐ N/A

Total Annual Household Income: $ _____

Total Outstanding Medical Bills: $ _____

(Copies of medical bill documentation required within 2 weeks)

Income Verification: Acceptable household income documentation is listed below. Please submit required copies with 2 weeks.

☐ Paycheck Remittance ☐ Employer Verification ☐ Tax Return ☐ SS Determination Letters

☐ IRS Form W-2 ☐ Workers Compensation or Unemployment Compensation Determination Letters

☐ Bank Statements ☐ Governmental Assistance (Food Stamps, CDIC, Medicaid, TANF)

☐ **Other** _____ ☐ **None (Written Attestation Form Required)**

Family Members: Provide the total number of people in the patient's household: _____

Please note: This number should only include the patient, patients' dependents **unless the patient is a minor**; include the patient, the patient's parents and parents' dependents(if any).

I understand Blue Star Imaging may verify the financial information contained in this Financial Assistance Application("Application") in connection with Blue Star Imaging's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance. I further understand that some physician and providers may not be employees of Blue Star Imaging. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

Signature of Patient or Responsible Party Printed Name Date

For Internal Use Only:

Application information obtained by Blue Star Imaging Employee in person or over the phone, **no patient signature required.**

Blue Star Employee Name Printed **Date**

Notes Re: Income/Household Size: _____

Patient is verified Community Care Program? ☐ Yes ☐ No **Program Name:** _____

FINANCIAL ASSISTANCE SUMMARY

BLUE STAR IMAGING

ELIGIBILITY REQUIREMENTS:

All patients are eligible to apply for financial assistance including those with insurance. Established discount guidelines are utilized to determine what amount, if any, will qualify for financial assistance.

Generally,

patients with family income at or below 200% of the Federal Poverty Guidelines (FPG) will receive a 100% discount. Patients with family incomes ranging from greater than 200% up to 500% of FPG, with medical bill exceeding 5% of their yearly income may also be eligible for a discount of up to 90% off billed charges.

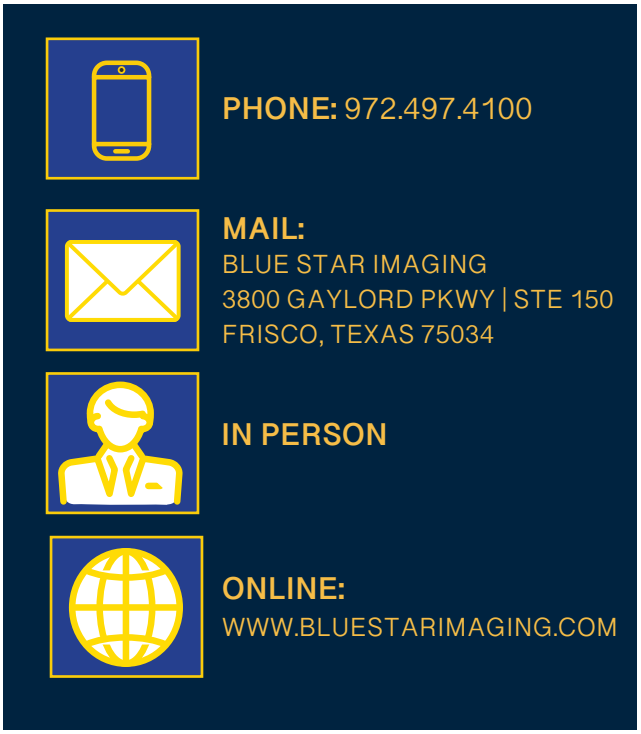
When a patient's circumstances do not satisfy the requirements under the established discount guidelines, a patient may still be able to obtain financial assistance. In these situations, a Blue Star representative will review available information and make a determination on the patient's eligibility for financial assistance.

The patient's situation will be evaluated according to relevant circumstances, such as income, assets or other resources available to the patient or patient's family and the outstanding balance.

Additionally, Blue Star can initiate an assistance application on behalf of the patient. There is no assurance that the patient will qualify for financial assistance. English, Spanish and certain other language versions of this communication, the FAP and the FAP application are available up request.

How to apply for Financial Assistance

Free copies of the FAP and the FAP application can be obtained through any of these sources:



Charges for emergency or medically necessary care:

No patient who qualifies for Financial Assistance will be charged more for emergency or other medically necessary care than amounts generally billed to patients having insurance.