The Behavioral Wellness Center at Girard

Financial Assistance Program Application

The Behavior Wellness Center at Girard offers financial assistance for medically necessary care provided to eligible individuals and families. Your financial needs will determine a reduction of elimination of your financial obligation.

You may qualify for the Behavior Health Center Financial Assistance Program (FAP) if you:

Have limited or no health insurance coverage.

Are not eligible for government assistance such as Medical Assistance.

Cooperate in providing necessary information to support your financial needs.

The Process to apply for Financial Assistance is as follows:

Complete the Bewell financial Assistance Program Application

Include documentation listed on checklist.

In order to determine eligibility, the hospital will need proof of your income and household size (we use the Federal Poverty Guidelines to determine financial needs)

Income used to determine eligibility includes, but not limited to : Wages, Social Security, IRA, interest, Pension, Disability, Workers Compensation, and Unemployment Compensation.

If needed, Bewell will assist in establishing a payment plan for any balance for which you are financially responsible.

After you complete the application, Bewell will notify you if you qualify for the Financial Assistance Program.

Health Insurance must be listed on the application.

You will be required to complete a Medical Assistance application in addition to this process.

Failure to cooperate in the Medical Assistance application process will terminate you FAP eligibility.

If you have any questions regarding this application please contact the Bewell Medical Assistance application Coordinators at 215-787-2362 or 215-787-2530, Monday to Friday 8AM to 4:30PM.

The Behavior Wellness Center at Girard
Philadelphia, Pa. 19122

Notice of Availability of Uncompensated Services

North Philadelphia Health System is required by law to give a reasonable amount of its service without charge to eligible persons who cannot afford to pay for health care.

The Department of Health and Human Services published in the Federal Register the latest poverty guidelines. To be eligible to receive subsidized care, your family income must be at or below the following levels:

Size of family	Category A 100% of Poverty	Category B 200 % of Poverty
1	$12,880	$25,760
2	$17,420	$34,840
3	$21,960	$43,920
4	$26,500	$53,000
5	$31,040	$62,080
6	$35,580	$71,160
7	$40,120	$80,240
8	$44,660	$89,320
8+	Add $4,540 for each additional Family Member	Add $9,080 each additional Family Member

Annual Income Limit Effective: 01/01/2022

If you think you may be eligible for uncompensated services, please contact a Financial Counselor at (215) 787-2350 or 787-2362 and you will be required to bring **Proof of Income** such as pay stub or Federal Income Tax return, with your written request.

North Philadelphia Health System will decide your eligibility for uncompensated services within two (2) working days of your request.

The Behavior Wellness Center at Girard

Application for Free, or below Charges

Application is made based on the information given below for free or below charge. I understand that this information must be true and accurate to the best of my knowledge and that the facility may take any reasonable action to verify. If the information proves to be untrue, the facility may review my case and take whatever action becomes suitable.

☒ _____ _____

Signature of Patient, Guarantor or Representative Date

The patient is required to formulate application for any help (Medicaid, Medicare or Insurance) which may be available for payment to the hospital.

Income of Family:

	Number in same Household	Income for the Last 3 months	Income for the last 12 months
Single Person			
Husband			
Wife			
Children			
Other Dependents			
Total Family Size			

Services provided on (date) _____ (discharged) _____

Business Office Use Only

☐ **Approval:**

On _____, I determined that the above patient is eligible for free care, and have advised the patient.
Date

☐ **Denial:**

On _____, I determined that the above patient was not eligible for free care, and have advised the patient what the reason for denial is

_____

_____

☒ _____ _____

Signature of Financial Counselor/Manager/Director Date

(Income includes wages before deductions, receipts from self-employment, public assistance payments, social security, unemployment and workers' compensation, strike benefits, veterans' benefits, training stipends, alimony, child support and military family allotments or other regular support from an absent family member, regular insurance or annuity payments, dividends, rent, interest, royalties, or income from estate and trusts.)