

BLA PARTNERS, LLC

2017 BLA Partners “Financial Affordability in Recovery” Form

Purpose:

BLA Partners, LLC and BLA of Massachusetts, LLC, together herein referred to as “BLA”, understand that sometimes the cost of treatment creates a financial burden for patients. For this reason, we created the *Financial Affordability in Recovery* program, also referred to as “FAIR”. The establishment of this policy maintains consistency in supporting patients eligible for financial support and helps in the successful recovery of patients completing their treatment plans. BLA will review the financial circumstances of each applicant and apply this policy consistently.

Patients who qualify for financial support will receive reductions up to 100%.

Financial Support Criteria:

BLA uses the current year’s federal poverty guidelines to help determine if an applicant qualifies for a financial support (Attachment A).

Several forms or proof of income will be allowed when determining whether or not a patient meets program eligibility requirements. Written verification, when available, may be required to substantiate and verify information contained in the FAIR application. In applying these guidelines, BLA may review income and employment status verification, including tax returns, check stubs, etc.

Application Process for Financial Support:

Financial support of laboratory charges must be made in accordance with BLA’s policy entitled “**Financial Affordability in Recovery Policy**”.

Applicants can request and complete a **FAIR Form**. The form can be obtained by calling 1-844-850-7180, emailing us directly at FAIR@burlingtonlabs.com, visiting any of the BLA facilities during normal business hours or going to the BLA website www.burlingtonlabs.com. Forms can also be requested from the BLA business office through submission of a written request to BLA Partners, 199 Main Street, Attn: Billing Dept., Burlington, VT 05401. Applicants are required to return the completed forms and submit all required documentation to BLA.

Required Information:

BLA requires personal financial information to support claims of financial hardship. The information submitted will be treated confidentially and will only be reviewed by the BLA administrative staff involved in processing requests for waiver of laboratory charges.

Time Frame:

After an application and verification information is received, BLA will consider the overall financial situation of the applicant and then render a decision. BLA has designated the authority to grant or reject requests for financial support to the Billing Supervisor. **All decisions will be made within 10 business days from the time that BLA receives all required information.**

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Applicants will receive a notification letter outlining whether or not the application has been approved or rejected. If the request for waiver of the charges is rejected, BLA will provide the applicant with a written summary and explanation of its decision. If the applicant’s situation changes, the patient or their designee may reapply.

BLA’s administrative staff will maintain all documentation related to the FAIR program. This includes the FAIR application form and all documents provided in support of the request.

If an applicant is deemed to be eligible to receive financial support, the eligibility will be in effect for **one year** from the effective date. Verification of ongoing qualification for financial support may be conducted at any time.

Patients have up to 90 days from date of service to submit their application to apply their eligible financial support to the services performed.

Income shall be annualized from the date of request based on documentation provided by the patient or their designee.

***PLEASE COMPLETE THE ATTACHED FINANCIAL AFFORDABILITY IN RECOVERY APPLICATION FORM.
YOUR REQUEST CAN NOT BE PROCESSED UNLESS THE APPLICATION AND FINANCIAL DATA IS FULLY
COMPLETED AND SIGNED!***

Financial Affordability - Attachment A

2017 POVERTY GUIDELINE QUALIFICATION

BLA provides financial support to patients with an annual household income at or below the amounts reflected here:

Persons in Family/Household	400% of Federal Poverty Guidelines (BLA’s maximum household income to qualify for Financial Support)
1 Person	\$48,240
2 Persons	64,960
3 Persons	81,680
4 Persons	98,400
5 Persons	115,120
6 Persons	131,840
7 Persons	148,560
8 Persons	165,280
For families/households with more than 8 persons	Add \$16,720 for each additional person

Financial Affordability in Recovery Application Form

Patient Information

Patient full legal name:		Date of birth:
SSN:	Phone:	Email address:
Current address:		
City:	State:	ZIP Code:

Insurance information

Does the patient have medical coverage? YES NO (please circle one)	IF "YES" please list responsible party information (Please include a copy of insurance card):
Insurance Company Name:	
Address:	
Phone number:	Policy holder name and ID:

Financial Information (all values should reflect yearly amounts for the entire household)

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Financial	Total Gross Yearly Income (before taxes) \$ _____ (Include pay stub, W-2, unemployment or disability statement, or other verification of income)
	Household Size: _____ (Number of people who contribute to or are dependent on your household income) Your application may be subject to audit or request for additional documentation

Check here if you are unemployed. How Long? _____

Are you collecting unemployment benefits? Yes No

Check here if you are on Social Security. How Long? _____

Check here if you are on Disability. How Long? _____

PLEASE LIST ALL CURRENT EMPLOYERS

Employer 1: _____

Employer 2: _____

Financial Affordability in Recovery Application Form (Continued)

Please provide proof of income documentation. Appropriate documentation for financial support would be the following:

- 1) At least **ONE** documented proof that patient is at or below 400% of the current federal poverty guidelines. Patient must submit any of the following that apply:
 - Income tax return (copy of the most recently signed 1040 Tax Return)**
 - Pay check stubs for the past 90 days for all persons employed in the home**
 - Current year Social Security or Disability letter with benefit amounts**
 - Proof of all other income received in the past 90 days, including unemployment benefits**
 - Application forms from Medicaid or other state-funded medical assistance program**

I hereby acknowledge that the above information is true and correct according to the best of my knowledge and belief. I authorize "BLA" (BLA Partners, LLC) to verify the above information for the sole purpose of assessing financial need. I understand that if I do not qualify, I will be notified and BLA will bill me directly. I have agreed to notify BLA if my financial condition changes or improves.

Patient Name (Print) _____	Date: _____
Patient Signature: _____	Date: _____
Responsible Party Signature: _____	Date: _____

BLA PARTNERS, LLC

Mail completed application to:

BLA Partners, LLC
 199 Main Street, Suite 226
 Burlington VT, 05401

For Internal use only:

Accession numbers (attach list)	Amount \$	Approved	Denied
Dates of service coverage begins:			
Dates Financial Aid Expires:			
Date Received:	Date Approved/Denied	PSC Rep <\$1K: _____ Supervisor Signature >\$1K & <\$5K: _____ CFO Signature >\$5K: _____	