TURQUOISE LODGE HOSPITAL **Avatar Case No** _____

SLIDING FEE ELIGIBILITY DETERMINATION AND PAYMENT CONTRACT **TL Case No** _____

CONFIDENTIAL

Patient's Name _____ Date of Adm _____ Date of Discharge _____

APPLICANT'S STATEMENT:

SECTION A.

Mailing Address _____

City _____ **State** _____ **Zip** _____ **Phone** _____

SECTION B.

Marital Status: Married __ Single/Never Married __ Separated __ Divorced __ Widowed __

Head of Household? Yes __ No __ **Gender:** Male __ Female __

SECTION C.

Your Social Security No. _____ Date of Birth _____

Do you have Health Insurance? Yes __ No __ If yes, complete the following:

Name of Insurance Company _____

Address _____

Policy No. _____ Group No. _____ Ind. No. _____

Has this party been contacted? Yes __ No __ By Whom? _____

Approved Denied What are payment arrangements?

Do you have any other insurance or coverage through **Spouse**, **Employer**, **Union**, **Agency**, **Tribal** or **Government Program**, etc?

Yes No If yes, complete the following:

Name of "Other" _____

Address _____

Has this party been contacted? Yes No By Whom? _____

Approved Denied What are payment arrangements?

SECTION D. (Needs to be filled out completely)

Are you: Un-Employed __ Employed: Full-Time __ Part-Time __ Weekly Hours ____

Retired __ Other (Specify) _____

_____ _____ _____

(Present Employment) (Your Occupation) (Mo. Salary)

If unemployed, how long? _____ Reason _____

Where is spouse employed? _____

(Mo. Salary)

SECTION E. Please fill out all information (N/A if not applicable)

Indicate household's Gross Monthly Income from: Retirement Pension $ _____

Alimony $ _____ SS (SSI or SSD)$ _____ Self Employment $ _____

Veteran's Pension/COMP $ _____ Welfare $ _____ Food Stamps $ _____

Investments or Interests $ _____ Child Support $ _____

Unemployment Insurance $ _____ Other (Specify): _____ $ _____

Did you file an income tax return for last year? Yes No

(If "No" but they did work part of this year, they will need to send a copy of income tax or their last paycheck stub for financial assistance.)

SECTION E.

Income Recapitulation for Applicant and All Household Members

NAME OF HOUSEHOLD MEMBERS	SEX	BIRTH DATE	RELATIONSHIP
Applicant:			

Are you paying Child Support? Yes No Amount of Child Support Paid? _____

Total Annual Household Income Before Deductions _____

(Should Equal 12 Times Total of Sections D. & E.)

SECTION G. (To Be Read By Or To Applicant Before Signing)

Being fully aware that to deliberately withhold information or to give false information to obtain assistance for which I am not eligible may subject me to prosecution for fraud and the legal penalties applicable thereto, I, the undersigned applicant, do hereby certify that I

- ☐ (am) a resident of New Mexico, that the foregoing information is complete, true and correct to the best of my knowledge. I agree to provide documentation necessary for verification; otherwise I am responsible for all charges.
- ☐ (am not) a resident of New Mexico, that the foregoing information is complete, true and correct to the best of my knowledge. I agree to provide documentation necessary for verification; otherwise I am responsible for all charges.

I hereby authorize Turquoise Lodge and/or its employees to release information regarding my treatment for drug or alcohol abuse and mental health problems as is necessary for processing my Third Party Reimbursement Claim to the parties identified in foregoing Sections C And D. I understand that this authorization remains valid until settlement of the claim by the third party or denial of payment is received (per CFR 42).

Applicant's Signature_____ Date _____

Parent or Guardian Signature _____ Date _____

Staff Signature_____ Date _____

I, the undersigned, hereby agree to pay the charges for my treatment at Turquoise Lodge Hospital per the above payment plan. These charges will be based on established rates for treatment services and as reduced by Third Party Reimbursement, if any, and/or Certification of Eligibility for Financial Assistance as determined in the foregoing.

I understand that Turquoise Lodge Hospital does not have the authority to forgive debts owed to the State of New Mexico, and hereby authorize the acknowledgment of my account with Turquoise Lodge Hospital to their Designated Credit and Collection Representative to allow for collection of delinquent accounts.

Patient's Signature _____ Date _____

Parent or Guardian Signature_____ Date _____

Staff Signature_____ Date _____

SECTION H. (For Internal Use Only - Turquoise Lodge Hospital)

(Complete after financial information is received)

Percent Financial Assistance	Percent Pay Patient	Number of Individuals in Family (Household)								Federal Poverty Guidelines (FPL)	Effective 4/1/15 - 3/31/2016
		1	2	3	4	5	6	7	8	9	10
100%	0%	0 to 15,660	0 to 21,192	0 to 26,724	0 to 32,256	0 to 37,788	0 to 43,320	0 to 48,852	0 to 54,384	0 to 59377	0 to 64370
90%	10%	16,965	22,958	28,951	34,944	40,937	46,930	52,933	58,916	64,370	69,363
80%	20%	18,270	24,724	31,178	37,632	44,086	50,540	57,014	63,448	69,363	74,356
70%	30%	19,575	26,490	28,158	40,320	47,235	54,150	61,095	67,980	74,356	79,349
60%	40%	20,880	28,256	33,405	43,008	50,384	57,760	65,176	72,512	79,349	84,342
50%	50%	22,185	30,022	35,632	45,696	53,533	61,370	69,257	77,044	84,342	89,335
40%	60%	23,490	31,788	37,859	48,384	59,831	64,980	73,338	81,576	89,335	94,328
30%	70%	24,795	33,554	40,086	51,072	62,980	68,590	77,419	86,108	94,328	99,321
0%	100%	26100+	35320+	42313+	53760 +	66129+	72,200+	81,500+	90,640+	99,321+	104,314+

DETOX	3 days	X	$650.00		1,950.00	_____%	
REHAB	30 DAYS	X	$550.00		16,500.00		(Most Insurance companies will pay Detox)
You will be charged only the percentage of balance					18,450.00		

Treatment Assistance Certification: Based upon the foregoing statement or Reported Annual Income

$_____ which has been verified by: _____

(Attach Copies)

1. _____ The Applicant is Certified for Financial Assistance:

_____% Assistance Portion _____% Applicant Portion

Payment Plan for Applicant's Portion _____

_____

__ Service not based on ability to pay
__ TLH will accept payments you are able to pay

2. _____ The Applicant is **NOT** Certified for Financial Assistance:

_____% Assistance Portion _____% Applicant Portion

Payment Plan for Applicant's Portion _____

Notes: _____

_____

Signature Date

Finance Department Date

1-505-383-1123

Revised 5/4/2015