Need Financial Assistance?

As part of its mission and commitment to the community, The Breastfeeding Success Company (BFS) provides financial assistance to patients who qualify for assistance pursuant to BFS's ' Financial Assistance Policy (FAP).

Eligibility requirements:

Established discount guidelines are utilized to determine what amount, if any, will qualify for financial assistance. The level of financial assistance will be based on the eligible patient's classification of financial or medical need or for uninsured patients.

- Medically Indigent Patients: Generally, qualifying patients with an income that *exceeds* 200% of the Federal Poverty Guidelines, but whose medical bills after payment by all third parties exceed 5% of their Total Yearly Income and who are unable to pay the remaining bill may qualify for a 50% discount.
- Financially Indigent Patients: Generally, qualifying patients with income at or below 200% of the Federal Poverty Guidelines (FPG) will receive a 100% discount.
- Uninsured Patients: BFS considers a patient to be an "uninsured patient" if (a) the patient lacks insurance, or (b) the patient's insurance does not cover the specific BFS service being provided to the patient. It is BFS's policy to provide all uninsured patients a percentage discount based on the patient's total yearly income and household size.

How to apply for financial assistance:

Patients or their responsible party who desire to apply for financial assistance shall complete a Financial Assistance Application form (*See* Exhibit A) and return it to any of these sources:

By Fax: 512-498-0211
Online: www.bfsuccess.com
By mail: The Breastfeeding Success Company
Attention: Financial Assistance
111 Ramble Lane, #115
Austin, TX 78745

NON-PAYMENT

After a patient's account is reduced by any discounts available under this Policy, the patient or responsible party will be responsible for the remainder of his or her outstanding patient accounts. Patients will be invoiced for any remaining amounts in accordance with BFS's Billing & Collections Policy.

EXHIBIT A

FINANCIAL ASSISTANCE APPLICATION

I/we ask The Breastfeeding Success Company to determine if I/we are eligible for help in paying my/our bill. I/we understand that I/we need to give certain information for this to be done. I/we also understand that The Breastfeeding Success Company or its agents will check these facts for accuracy. I/we understand that filling out this form does not guarantee that I/we will receive this help. If I am (we are) not eligible for uncompensated services, I am (we are) responsible for my own and my child's Provider bill.

Patient's Name: ______________________________ ______________________________

First / Middle / Last Date of Birth

Baby's Name: ______________________________ ______________________________

Address: ____

Street / City / State / ZIP

Patient's (or Responsible Party's) Total Yearly Income*:

$______________________________

Patient's total medical bills

$______________________________

Are your total medical bills greater than 5% of Total Yearly Income?

Yes or No (Please circle one)

Household Size:

____

* The term "***Total Yearly Income***" means the sum of the total yearly gross income of the patient or the responsible party.

I/we declare that the answers I/we have given are true and correct to the best of my/our knowledge.

I/we understand that if I/we do not qualify for discounted services, I/we will be personally liable for the charges of the services rendered by The Breastfeeding Success Company.

Signature of Patient/Responsible Party ______________________________ Date: ______________

For use by BFS

Fee for Review: ______

Discount Granted: ______

Final Amount: ______

Approved: ______ ______

First Name / Last Name / Title Date

Approved: ______ ______

First Name / Last Name / Title Date