BELLA
health + wellness
WOMEN • MEN • CHILDREN

Financial Assistance Program

Bella Health + Wellness's Financial Assistance Program offers discounts or free care to those who financially qualify. If a patient qualifies the discount or free care will be applied to emergency or medically necessary services provided by Bella Health + Wellness during a specified time period. The application is available to all Bella Health + Wellness patients who request assistance.

Who Qualifies for Bella's Financial Assistance Program?

To qualify for free care your gross household income must be at or below 200% of the federal poverty level.
OR
Your out-of-pocket healthcare costs for emergency and/or medically necessary services are more than 10% of your gross household income (for a 12-month period).
*Out-of-pocket costs include deductibles and coinsurance. Do NOT include plan premium payments or copays

Household size	Monthly Household Income	Annually Household Income
1	$2,146	$25,760
2	$2,903	$34,840
3	$3,660	$43,920
4	$4,416	$53,000
5	$5,173	$62,080
6	$5,930	$71,160

**chart shows* 200% of 2021 Poverty Guidelines for the 48 contiguous states and the District of Columbia
*add $9,080 for each additional household member above 6

Disclosures

- You may be required to provide proof of income.
- You may be required to apply for CO Medicaid and/or CO Access.
- You may need to show proof that you have applied for CO Medicaid and have been approved or denied.
- You must provide all active insurance coverages you may have.

Financial Assistance Application

Patient Name_____ Date of Application_____

Date of Birth_____ Contact phone #_____

Address_____ City_____ State___ Zip____

Please list the total number of family members (including you) in your household_____

Please list all members of your household

Name	Relationship	DOB
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total gross income for all family members (monthly)_____

*This would include employment income, business income, rental property income, unemployment benefits, child support, alimony, pension or retirement, social security

Total out-of-pocket healthcare expenses (last 12 months)

_____

*This would include costs for any emergency or medically necessary services provided by Bella Health + Wellness and/or any healthcare provider. You may include deductible and coinsurance payments.

I state that the information I put on this application is true and best to my knowledge. I also acknowledge that I am liable for any amounts owed to Bella Health + Wellness that are not eligible for financial assistance.

Signature_____ Date_____