C

FINANCIAL HARDSHIP APPLICATION

FOR WAIVER OF COPAY/DEDUCTIBLE

The patient will need to complete a financial disclosure form (see attachment B) and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1) Documented proof that patient is at or below 200% of the current federal poverty guidelines (see attachment B for 2008 guidelines). This can include documents such as:

   a. W-2 withholding statements
   b. Pay check stubs
   c. Income tax return
   d. Forms from Medicaid or other State-funded medical assistance
   e. Forms from employers or welfare agencies.

2) Patient has other circumstances that indicate financial hardship. These can be situations such as:

   a. proof of bankruptcy settlement
   b. catastrophic situations (death or disability in family, divorce)
   c. or other documentation that shows that patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses.

Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

Any denial of "financial hardship" discount request will be written and will include instructions for reconsideration. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered per the above guidelines.

Completion of this application does <u>not</u> mean your request will be granted or that you will be relieve of financial responsibility.

All information relating to financial hardship requests will be kept confidential.

FINANCIAL DISCLOSURE FORM

Financial Hardship Discount Information Needed. HHS Poverty Guidelines-Used to determine financial hardship based on income.

2012 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$11,170	$13,970	$12,860
2	15,130	18,920	17,410
3	19,090	23,870	21,960
4	23,050	28,820	26,510
5	27,010	33,770	31,060
6	30,970	38,720	35,610
7	34,930	43,670	40,160
8	38,890	48,620	44,710
For each additional person, add	3,960	4,950	4,550

Please provide following information so we may complete your application:

- ☐ Most recent IRS tax forms (1040 and/or W-2) (Must be signed)
- ☐ Check stubs for the past 30 days for all persons employed in the home
- ☐ Unemployment check stubs for the past 30 days
- ☐ Drivers license or identification card for adults
- ☐ Proof of al other income received in the past 30 days
- ☐ Proof of all outstanding bills (payment stubs, cancelled checks, etc.)
- ☐ DSHS Denial letter
- ☐ Medicaid forms or card
- ☐ Attached financial statement (completely filled out and signed)

Please be sure to sign the attached financial statement. Your request will NOT be processed if this is not signed.

Please return all items (as applicable) on this checklist (in person or by mail).

Financial statement payment plan/uncompensated services application.

PATIENT NAME: _____

DATE(S) OF SERVICE:

NAME OF RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT: _____

SPOUSE: _____

TELEPHONE: _____

ADDRESS: _____

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD): _____

EMPLOYER: _____

ADDRESS: _____

IF UNEMPLOYED, HOW LONG?: _____

SPOUSE'S EMPLOYER: _____

ADDRESS: _____

IF UNEMPLOYED, HOW LONG?: _____

OTHER FAMILY MEMBER'S EMPLOYER(S):

(INCLUDE MEMBER NAME, EMPLOYER & ADDRESS)

_____

_____

_____

MONTHLY FAMILY INCOME & SOURCE

_____Patient _____Spouse _____Responsible Party _____Children Working

Monthly Salary (Gross) $ _____

Public Assistance Benefits $ _____

Unemployment Benefits $ _____

Social Security Benefits $ _____

Workman's Compensation $ _____

Child Support $ _____

Other (Alimony, Etc.) $ _____

TOTAL FAMILY INCOME $ _____

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE (YOUR COMPANY] TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

_____ _____
Signature of Person Making Request Date:

_____ _____
Signature of Spouse/Other Date:

DO NOT WRITE BELOW THIS LINE - FOR OFFICE PERSONNEL USE ONLY

This document was received on _____ (date)

by _____ (Name/Title)

Approved by _____
(signature of provider/practitioner or office manager)