PATIENT FINANCIAL HARDSHIP APPLICATION

Our practice abides by the contractual and legal obligations of health benefit plans to collect charges, co-pays, co-insurance and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full at the time of service, we have adopted a policy of screening requests for discounts, delayed payment plans or forgiveness of debt based on individual circumstances. To do this, we must ask for certain financial information. *All information will be held confidential according to our privacy policy.* Please provide the documents listed below for each adult family member, and complete this form to the best of your ability:

• A copy of last year's federal tax return;

• Copies of the two most recent payroll stubs or unemployment benefit payments;

• If income is close to or below the poverty level, documentation that state medical assistance has been applied for and denied.

Patient name: _____Patient date of birth: _____

Number of dependents in household: _____

Phone: _____

Employment/unemployment information (for each adult family member)

Name: _____ Employer:_____

Address:_____

Phone: _____

Name: _____ Employer: _____

Address:_____

Phone: _____

Name: _____ Employer:_____

Address:_____

Phone: _____

Name: _____ Employer: _____

Address:_____

Phone: _____

If unemployed, please state when employment was terminated. If lay-off is temporary, indicate expected duration:

_____

_____

Assistance received

☐State financial assistance ☐WIC ☐Food stamps ☐CHIP

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Please complete the information in the following table based on average income and expenses over the last 12 months. For amounts paid annually, enter annual amount divided by 12.

Household financial information

Monthly income (after payroll deductions)		**Monthly expenses (not including payroll deductions)**	
Employment	$	Mortgage/rent	$
Unemployment/severance	$	Auto/transportation	$
Self-employment	$	Non-reimbursed work expenses (e.g., parking, tools)	$
Interest/dividends	$	Insurance (e.g., life, homeowners)	$
Pension/disability	$	Utilities (e.g., lights, water, gas)	$
Child support/alimony	$	Medications	$
Short-term disability	$	Childcare	$
Long-term disability	$	Credit cards	$
Rental income	$	Child support/alimony	$
Other income:	$	Personal property taxes (home, auto)	$
	$	Other expenses:	$
	$		$
Total average income	$	**Total average expenses**	$

By my signature below, I certify that this information is true and complete. I grant this office permission to verify the information, and I acknowledge that completion of this form does not guarantee discount, payment plan or forgiveness of debt.

Signed: _____ Date: _____

Approved by: _____ Date:_____

Approved for:

☐Reduced deductible ☐Reduced co-pay/co-insurance

☐Payment plan ☐Debt forgiveness