

## 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: \_\_\_\_\_

Your name: \_\_\_\_\_ Name of other responsible party: \_\_\_\_\_

Number of dependents in household: \_\_\_\_\_ Number in school: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

### Type of assistance requested

- Reduced deductible       Reduced co-pay/co-insurance       Discounted cash services  
 Payment plan       Debt forgiveness

### Employment/unemployment information (for each adult family member)

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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

## Property/investment values

	Address or description	Value
Home		\$
Other real estate owned		\$
Land		\$
Business		\$
Livestock		\$
Savings/stocks/bonds		\$
Other investments		\$

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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, trash)	\$
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:	\$
	\$		\$
<b>Total average income</b>	\$	<b>Total average expenses</b>	\$

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: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Approved for: \_\_\_\_\_

Next review date: \_\_\_\_\_