**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) | $ |
| 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:

Reviewed by:  Date:

Approved for: