|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Financial Hardship Application** | | | | | | | | | | |
|  |
| **Patient Information** | |  | | | | | | |  | |  |
|  | |  | | | | | | |  | |  |
| First Name: | | Last Name: | | | | | | | MI: | |  |
|  | |  | | | | | | |  | |  |
| Date of Birth: | | SSN: | | | | | | |  | |  |
| **Payee Information (Person Responsible for Payment)** | | | | | | | | |  | |  |
|  | |  | | | | | | |  | |  |
| First Name: | | Last Name: MI: | | | | | | | Relationship: | |  |
|  | |  | | | | | | |  | |  |
| Date of Birth: | | SSN: | | | | | | |  | |  |
|  | |  | | | | | | |  | |  |
| Street Address: | |  | | | | | | |  | |  |
|  | |  | | | | | | |  | |  |
| City: | | State: | | | | | | | Zip: | |  |
|  | |  | | | | | | |  | |  |
| Home Phone: | | Work Phone: | | | | | | | # Of Dependents: | |  |
| **Household Monthly Income** | | | |  | |  | |
|  | | Person 1 | | Person 2 | | Person 3 | | |
| Monthly Wages/Salary | |  | |  | |  | | |
| Unemployment | |  | |  | |  | | |
| Social Security/Pensions | |  | |  | |  | | |
| Alimony/Child Support | |  | |  | |  | | |
| Other | |  | |  | |  | | |
| **Total Income:** | |  | |  | |  | | |
| **Household Monthly Expenses** | | | |  | |  | |
|  | | Person 1 | | Person 2 | | Person 3 | | |
| Mortgage/Rent | |  | |  | |  | | |
| Utilities: Electric/Gas/Water | |  | |  | |  | | |
| Food/Grocery | |  | |  | |  | | |
| Credit Cards | |  | |  | |  | | |
| Car Payments | |  | |  | |  | | |
| Gasoline | |  | |  | |  | | |
| Insurance | |  | |  | |  | | |
| Phone | |  | |  | |  | | |
| Other | |  | |  | |  | | |
| **Total Expenses:** | |  | |  | |  | | |

**The following items must accompany the application in order to be considered – Where applicable, include pay stubs from both the patient, spouse and/or guardian of dependent patients.**

1. Copies of last 2 most recent pay stubs.
2. Copy of the previous year’s tax return.
3. Copy of the most recent bank statement with transaction details.
4. Medicaid or other State/Federal forms, such as disability, as proof of denial or pending status.
5. Any other documentation to prove you are unable to pay your medical bills and still be able to pay for basic, necessary, expenses (Housing, Food, Utilities).

Please read and sign the following verification:

I attest the information written above is accurate and complete, to the best of my knowledge. I understand that this application will be denied for any falsification of information or documents. I understand this is an application only, and not a guarantee of assistance. I also understand that this application is confidential. I understand that if approved, the approvals term is for 3 months and re-application will be necessary for additional consideration.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *✖* |  |  |  |  |
| **Responsible Person's Signature** | |  | **Date** | |

|  |
| --- |
| **For Business Office Use Only:**  Approved Assistance? YES/NO \_\_\_\_\_\_\_\_ Percent %  Effective Dates of Assistance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date  Billing Office Manager or other Designee |