SAMPLE PATIENT FINANCIAL HARDSHIP APPLICATION

ABC Family Medicine 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