Financial Hardship Application

The patient will need to complete a financial disclosure form (see attachment B) and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1) Documented proof that patient is at or below 200% of the current federal poverty guidelines (see attachment B for 2008 guidelines). This can include documents such as

    a. W-2 withholding statements
    b. Pay check stubs
    c. Income tax return
    d. Forms from Medicaid or other State-funded medical assistance
    e. Forms from employers or welfare agencies.

2) Patient has other circumstances that indicate financial hardship. These can be situations such as:

    a. proof of bankruptcy settlement
    b. catastrophic situations (death or disability in family, divorce)
    c. or other documentation that shows that patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses.

Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

Any denial of “financial hardship” discount request will be written and will include instructions for reconsideration. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered per the above guidelines.

All information relating to financial hardship requests will be kept confidential.

OIG Special Fraud Alert (1994). OIG Advisory Opinion 97-4. Federal Register, Vol 65, No. 81, 4-26-00 pages 24401-2440742 CFR, section 1001.952 (k)HIPAA, section 231(h), section 1128A42 USC, Section 1320a-7aBBA, section 4331 False Claims Act, Public Law 104-191, Kennedy v Connecticut General Life Ins. Co (Case Law) 924 F.2d 698 (7th Cir. 1991) Managed Care Contracts

Attachment B

Financial Disclosure Form

Financial Hardship Discount Information Needed. HHS Poverty Guidelines-Used to determine financial hardship based on income.

2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline
1	$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890

For families/households with more than 8 persons, add $3,960 for each additional person.

2012 Poverty Guidelines for Alaska

Persons in family/household	Poverty guideline
1	$13,970
2	18,920
3	23,870
4	28,820
5	33,770
6	38,720
7	43,670
8	48,620

For families/households with more than 8 persons, add $4,950 for each additional person.

2012 Poverty Guidelines for Hawaii

Persons in family/household	Poverty guideline
1	$12,860
2	17,410
3	21,960
4	26,510
5	31,060
6	35,610
7	40,160
8	44,710

For families/households with more than 8 persons, add $4,550 for each additional person.

SOURCE: *Federal Register*, Vol. 77, No. 17, January 26, 2012, pp. 4034-4035

Please provide following information so we may complete your application:

- ❑ Most recent IRS tax forms (1040 and/or W-2) (Must be signed)
- ❑ Check stubs for the past 30 days for all persons employed in the home.
- ❑ Unemployment check stubs for the past 30 days.
- ❑ Drivers license or identification card for adults.
- ❑ Proof of all other income received in the past 30 days.
- ❑ Proof of all outstanding bills (payment stubs, cancelled checks, etc.)
- ❑ DSHS Denial letter.
- ❑ Medicaid forms or card
- ❑ Attached financial statement (completely filled out and signe)

Please be sure to sign the attached financial statement. Your request will NOT be processed if this is not signed!

Please return all items (as applicable) on this checklist (in person or by mail).

Financial statement payment plan/uncompensated services application.

PATIENT NAME: _____

DATE(S) OF SERVICE:

NAME OF RESPONSIBLE PARTY:_____

RELATIONSHIP TO PATIENT:_____

SPOUSE: _____

TELEPHONE: _____

ADDRESS:_____

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD):_____

EMPLOYER:_____

ADDRESS:_____

IF UNEMPLOYED, HOW LONG?:_____

SPOUSE'S EMPLOYER:_____

ADDRESS:_____

IF UNEMPLOYED, HOW LONG?:_____

OTHER FAMILY MEMBER'S EMPLOYER(S):

(INCLUDE MEMBER NAME, EMPLOYER, & ADDRESS

_____

_____

_____

MONTHLY FAMILY INCOME & SOURCE

__Patient __Spouse __Responsible Party __Children Working

Monthly Salary (Gross) $_____ Public Assistance Benefits $_____

Unemployment Benefits $_____ Social Security Benefits $_____

Workman's Compensation $_____ Child Support $_____

Other (Alimony, Etc.) $_____ TOTAL FAMILY INCOME$_____

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE [YOUR COMPANY] TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

_____ _____
Signature of Person Making Request Date:

_____ _____
Signature of Spouse/Other Date:

DO NOT WRITE IN BOX – FOR OFFICE PERSONNEL USE ONLY

This document was received on _____ (date)

by _____(Name/Title)

Approved by _____
(signature of provider/practitioner or office manager)