

## **FINANCIAL HARDSHIP APPLICATION**

### **FOR WAIVER OF COPAY/DEDUCTIBLE**

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

- 1) Documented proof the patient is at or below 200% of the current federal poverty guidelines. This can include documents such as:
  - a. W-2 withholding statements.
  - b. Paycheck 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 the patient would be unable to pay the 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.

Completion of this application does not mean your request will be granted or that you will be relieved of financial responsibility.

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

## FINANCIAL DISCLOSURE FORM

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

### 2024 HHS Poverty Guidelines

| # of Persons in Household                               | 2024 Federal Poverty Level for the<br>48 Contiguous States (Annual Income) |           |            |
|---|--|-----------|------------|
|   | 100%   | 150%      | 200%       |
| 1   | \$ 15,060  | \$ 22,590 | \$ 30,120  |
| 2   | \$ 20,440  | \$ 30,660 | \$ 40,880  |
| 3   | \$ 25,820  | \$ 38,730 | \$ 51,640  |
| 4   | \$ 31,200  | \$ 46,800 | \$ 62,400  |
| 5   | \$ 36,580  | \$ 54,870 | \$ 73,160  |
| 6   | \$ 41,960  | \$ 62,940 | \$ 83,920  |
| 7   | \$ 47,340  | \$ 70,010 | \$ 94,680  |
| 8   | \$ 52,720  | \$ 79,080 | \$ 105,440 |
| Add \$5,380 for each person in household over 8 persons |  |           |            |

### 2024 Sliding Fee Scale Based on Poverty Guidelines

| Poverty Level* | At or Below<br>100% | 150%      | 200%       |   |
|----------------|---------------------|-----------|------------|---|
| Household Size | Plan A              | Plan B    | Plan C     | Plan D  |
| 1              | \$ 15,060           | \$ 22,590 | \$ 30,120  | If you do<br>not share<br>your<br>income<br>information |
| 2              | \$ 20,440           | \$ 30,660 | \$ 40,880  |   |
| 3              | \$ 25,820           | \$ 38,730 | \$ 51,640  |   |
| 4              | \$ 31,200           | \$ 46,800 | \$ 62,400  |   |
| 5              | \$ 36,580           | \$ 54,870 | \$ 73,160  |   |
| 6              | \$ 41,960           | \$ 62,940 | \$ 83,920  |   |
| 7              | \$ 47,340           | \$ 71,010 | \$ 94,680  |   |
| 8              | \$ 52,720           | \$ 79,080 | \$ 105,440 |   |
| Discount       | 75%                 | 50%       | 25%        | 0%  |

Please provide following information (as applicable) 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
- ☐ Driver's 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 signed)

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: \_\_\_\_\_

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)

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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:

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DO NOT WRITE BELOW THIS LINE - FOR OFFICE PERSONNEL USE ONLY

This document was received on \_\_\_\_\_ (date)

by \_\_\_\_\_ (Name/Title)

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