PATIENT FINANCIAL HARDSHIP APPLICATION

Our financial assistance policy is offered as an option to patients needing additional assistance in paying for the care they receive in our office. Individuals and families who meet certain income requirements may be eligible to apply, or are facing certain financial difficulties. This application can be submitted quarterly. The completion of the application is NOT a guarantee that you will qualify, however to determine if you are eligible, you will need to provide us with the following items:

- Number of household members related by birth, marriage or adoption who are living together
- Your gross monthly individual and/or family income
- Declare any assets you may have (as listed in the application)
- Any additional information that may help determine your qualification/eligibility status
- Lastly, you must sign and date the financial hardship application

Patient name: _____ Patient date of birth: _____

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Patient name: _____ Patient date of birth: _____

Patient name: _____ Patient date of birth: _____

Your name: _____ Name of other responsible party: _____

Phone: _____

E-mail: _____

Type of assistance requested

□ Self-Pay discount (uninsured, including no other payer resource)

□ Insured patient discount

□ Payment plan

□ Total/Partial debt forgiveness (at OBHN discretion)

Notification of Approval

We will notify you within 30 days following the completion of the application and the review of all supporting documents provided if you qualify.

SHORT EXPLANATION OF HARDSHIP

FAMILY INFORMATION

List legal guardians including you.

Name & Birthdate	
Address	
Home Phone:	
Cell Phone	
E-mail Address	

Name & Birthdate	
Address	
Home Phone:	
Cell Phone	
E-mail Address	

Name & Birthdate	
Address	
Home Phone:	
Cell Phone	
E-mail Address	

Those related by birth, marriage or adoption living together (name and age)

_____

_____

_____

INCOME 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**	$

Supporting documents may be requested

Assistance currently received

☐ State financial assistance ☐ WIC ☐ Food stamps ☐ CHIP

Asset Information

	Address or description	Value
Home		$
Other real estate owned		$
Land		$
Business		$
Livestock		$
Savings/stocks/bonds		$
Other investments		$

Notes: _____

_____

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: _____