# Financial Hardship Application

## Instruction Page

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

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 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.

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## 2014 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

| Persons In Household | Poverty Guideline |
|---|---|
| 1 | $11,670 |
| 2 | $15,730 |
| 3 | $19,790 |
| 4 | $23,850 |
| 5 | $27,910 |
| 6 | $31,970 |
| 7 | $36,030 |
| | |

| | |
|---|---|
| 8 | $40,090 |
| **For households with more than 8 persons, add $4,060 for each additional person.** | |

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

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

# Disclosure Form & Financial Statement

**Please provide the following information:**

Patient Name _____ Date _____

Name of Responsible Party _____ Relationship to Patient _____

Patient's Home Address _____ Patient's Phone Number _____

Patient's Employer Name _____ Patient's Employer Address _____

**Is the Patient Unemployed? YES or NO If YES, how long?** _____

Spouse's Name _____ Spouse's Phone Number _____

Spouse's Employer Name _____ Spouse's Employer Address _____

**Is the Spouse Unemployed? YES or NO If YES, how long?** _____

How many people are living in your household? _____ List Names, Employers and Addresses below.

Household Member Name _____ Employer _____ Employer Address _____

| Household Member Name | Employer | Employer Address |
|---|---|---|
| Household Member Name | Employer | Employer Address |

**Who Contributes to the Monthly Household Income?**

☐ **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 ADVANCED PHYSICAL THERAPY OF CENTRAL FLORIDA, INC 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 |

## Supporting Documents

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

- ☐ 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 cards 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
- [ ] Completed and Signed Disclosure Form & Financial Statement (Page 2 of this application).

***DO NOT WRITE IN BOX – FOR OFFICE PERSONNEL USE ONLY***

This document was received on _____ (date)

by _____ (Name/Title).

Patient Name _____

Approved Co-Pay Amount: $ _____

Approved by _____
(signature of office manager)