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.

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:

hgk hgk	11/29/2017
Patient Name	Date
hgfh	jhggj
Name of Responsible Party	Relationship to Patient
kolkata	(098) 004-2294
Patient's Home Address	Patient's Phone Number
hgjhgj	jytuytu
Patient's Employer Name	Patient's Employer Address

Is the Patient Unemployed? YES , how long? 756

hgj	(098) 004-2294
Spouse's Name	Spouse's Phone Number
jhghg	jhgj
Spouse's Employer Name	Spouse's Employer Address

Is the Spouse Unemployed? YES , how long? 756

How many people are living in your household? 1

List Names, Employers and Addresses below.

ghj	hgj	hgj
Household Member Name	Employer	Employer Address

Who Contributes to the Monthly Household Income?

☐ **Patient** ☑ **Spouse** ☐ **Responsible Party** ☐ **Children Working**

$65.66	$66.00
Monthly Salary (Gross)	Public Assistance Benefits
$65.00	$6.00
Unemployment Benefits	Social Security Benefits
$6.00	$6.00
Workman's Compensation	Child Support
$6.00	$220.66
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.

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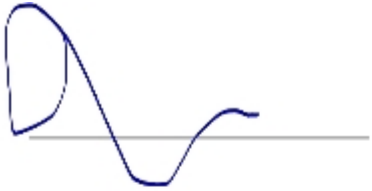

Signature of Person Making Request

Date

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Date

Signature of Spouse/Other

Supporting Documents

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

- [x] Most recent IRS tax forms (1040 and/or W-2). Must be signed.
- [x] Check stubs for the past 30 days for all persons employed in the home.
- [x] 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)