FINANCIAL HARDSHIP APPLICATION

Patient Name: _______________________________________ Date of Birth: _________________ Acct: ______________

Qualifications of Hardship Waiver

HPC allows a provision for waiving charges based upon specific circumstances and criteria for **recent** extreme financial hardship or recent catastrophic events; may include but is not limited to **sudden** change in housing status, recent job loss, current bankruptcy, and recent change in marital status, **current** medical crisis, disability or death. Catastrophic events such as fire, tornado, flooding, or other such occurrences.

Reason for Hardship Waiver Request [Provide a brief explanation of your circumstances and dates]

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Documentation/Proof of Hardship

Can you provide documentation supporting your hardship claim? For example, an eviction notice, notice of job termination, death certificate, etc.? ☐ Yes ☐ No ***If yes, please submit copy of documentation***

If no, cannot provide documentation supporting your hardship, can you provide contact information for someone who can attest to your hardship claim? ☐ Yes ☐ No

Name: _______________________________ Relationship: ___________________ Phone Number: ________________

Living Arrangement [Currently living alone, with someone, shelter, ect.]

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Name: _______________________________ Relationship: ___________________ Phone Number: ________________

Who currently pays for your everyday expenses? [Rent, Utilities, Food, Transportation, Clothing]

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Name: _______________________________ Relationship: ___________________ Phone Number: ________________

Attestation

I understand by signing this application, I am agreeing that Health Partnership Clinic may verify the information contained within. I further understand that this is a deferral of payment for this visit ONLY and does not apply to any prior or future balance on my account. I understand I will be notified by phone/mail regarding the approval or denial of my hardship application.

If my application is denied I will be responsible for the charges. _________ (Initial here)

Patient/Guardian Signature____ **Date Signed**_________________

COMPLETED BY HPC STAFF MEMBERS ONLY

Regarding Assistance:

If patient has completed FAA, what slide level has been assigned? ________________________

If patient has a pending Medicaid application or could be eligible for Medicaid has the navigator been notified?

☐ Yes ☐ No If yes, when? ____

Regarding Payment Plan:

Does patient have a balance due? ☐ Yes ☐ No If yes, Total $__________ Over 90 $__________Over 120 $__________

Payment History? ☐ Prompt-time of service/statement ☐ Payment plan – compliant ☐ Payment plan - delinquent

☐ Slow – past due ☐ Refusal to pay ☐ Bad debt write-off ☐ Sent to collections, when? ____________________________

Other comments or information to consider, if applicable? [Review of past history & current]

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Reviewer Signature ____ Date ___________________________

The Financial Hardship Application has been: ☐ Approved ☐ Denied

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Assessor Signature ____ Date _____________________________

Patient Notification

Date patient notified of decision ________________ Notified by ____

☐ Patient account documented ☐ If approved, waiver adjustment done in eCW billing system