Health Partnership CLINIC

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 within the last 90 days for extreme financial hardship or recent catastrophic events; may include but is not limited to change in housing status, job loss, and change in marital status, 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]

_____

_____

_____

_____

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.]

_____

_____

Name: _____ Relationship: _____ Phone Number: _____

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

_____

_____

_____

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]

_____

_____

_____

_____

_____

Reviewer Signature _____ Date _____

The Financial Hardship Application has been: ☐ Approved ☐ Denied

_____

_____

_____

_____

Assessor Signature _____ Date _____

Patient Notification

Date patient notified of decision _____ Notified by _____

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