Financial Hardship Application

The patient will need to complete a financial disclosure form (see attachment B) 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.

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

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

Attachment B

Financial Disclosure Form

Financial Hardship Discount Information Needed. HHS Poverty Guidelines-Used to determine financial hardship based on income.

2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline
1	$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890

For families/households with more than 8 persons, add $3,960 for each additional person.

2012 Poverty Guidelines for Alaska

Persons in family/household	Poverty guideline
1	$13,970
2	18,920
3	23,870
4	28,820
5	33,770
6	38,720
7	43,670
8	48,620

For families/households with more than 8 persons, add $4,950 for each additional person.

2012 Poverty Guidelines for Hawaii

Persons in family/household	Poverty guideline
1	$12,860
2	17,410
3	21,960
4	26,510
5	31,060
6	35,610
7	40,160
8	44,710

For families/households with more than 8 persons, add $4,550 for each additional person.

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

Financial Hardship Application

This is a special program that helps patients get the care they need when finances are an issue. All requests must be approved by the administrative staff. Not all requests are approved.

Staff Person Receiving Request_____ Date_____

Personal Information

Last Name	First Name	Social Security #	Driver's License #

Home Street Address	City	State	Zip

Home Ph.	Cell Phone	Email

Responsible Party

Full name of Responsible Party	Relationship to you

Home Street Address	City	State	Zip

Home Ph.	Cell Phone	Email

Household Information

Monthly Family Income & Source
❑Patient ❑Spouse ❑Responsible Party ❑Children Working

Employer: Name & Address

If unemployed, Why? How Long?

OTHER FAMILY MEMBERS'S EMPLOYER(S): NAME, ADDRESS

Income:

Monthly Salary (Gross) $	Workman's Compensation $
Public Assistance Benefits $	Child Support $
Employment Benefits $	Other Alimony, Etc.) $
Social Security Benefits $	TOTAL FAMILY INCOME $

Please tell us why we should approve your request?

Authorization

I HEREBT ACKNOWLEDGE THAT THE INFORMAITON GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE HOHMAN REHAB & SPORTS THERAPY, LLC TO VERIFY ANY INFORMAITON CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

Signature **X**_____

Date

For Office Use Only

What is the total amount that is/will be owed? _____ ❑ Approved ❑ Denied

Payment Amount $	Description	No. of Months	Total to be paid	
$	❑ Per month ❑ Other:			
$	❑ Per month ❑ Other:			
		Total		

Approved by_____ Date_____ Processed by_____ Date_____