

## 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 2023 guidelines). This can include documents such as
  - a. W-2 withholding statements
  - b. Paycheck 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.**

**Financial Disclosure Form**

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

**2023 HHS Poverty Guidelines**

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$14,580	\$18,210	\$16,770
2	\$19,720	\$24,640	\$22,680
3	\$24,860	\$31,070	\$28,590
4	\$30,000	\$37,500	\$34,500
5	\$35,140	\$43,930	\$40,410
6	\$40,280	\$50,360	\$46,320
7	\$45,420	\$56,790	\$52,230
8	\$50,560	\$63,220	\$58,140
For each additional person, add	\$5,140	\$6,430	\$5,910

SOURCE: <https://www.federalregister.gov/documents/2022/01/21/2022-01166/annual-update-of-the-hhs-poverty-guidelines>

Source: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

Please provide following information so we may complete your application:

- D Most recent IRS tax forms (1040 and/or W-2) (Must be signed)
- D Check stubs for the past 30 days for all persons employed in the home.
- D Unemployment check stubs for the past 30 days.
- D Driver's license or identification card for adults.
- D Proof of all other income received in the past 30 days.
- D Proof of all outstanding bills (payment stubs, cancelled checks, etc.)
- D DSHS Denial letter.
- D Medicaid forms or card
- D Attached financial statement (completely filled out and signee)

Please be sure to sign the attached financial statement. Your request will NOT be processed if this is not signed!

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

Financial statement payment plan/uncompensated services application.

# SPECIALTY

MEDICAL EQUIPMENT

52040 Van Dyke Ave  
Shelby Township MI 48316  
Tele: 877-622-3023 Fax: 313-221-5543

PATIENT NAME: \_\_\_\_\_

DATE(S) OF SERVICE: \_\_\_\_\_

NAME OF RESPONSIBLE PARTY: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

SPOUSE: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD): \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

IF UNEMPLOYED, HOW LONG? \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

IF UNEMPLOYED, HOW LONG? \_\_\_\_\_

OTHER FAMILY MEMBER'S EMPLOYER(S):

(INCLUDE MEMBER NAME, EMPLOYER, & ADDRESS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MONTHLY FAMILY INCOME & SOURCE

Patient     Spouse     Responsible Party     Children Working

Monthly Salary (Gross) \$ \_\_\_\_\_

Public Assistance Benefits \$ \_\_\_\_\_

Unemployment Benefits \$ \_\_\_\_\_

Social Security Benefits \$ \_\_\_\_\_

Workman's Compensation \$ \_\_\_\_\_

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Child Support \$\_\_\_\_\_

Other (Alimony, Etc.) \$\_\_\_\_\_

TOTAL FAMILY INCOME\$\_\_\_\_\_

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE [YOUR COMPANY] 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:

DO NOT WRITE IN BOX – FOR OFFICE PERSONNEL USE ONLY

This document was received on \_\_\_\_\_(date)

By \_\_\_\_\_(Name/Title)

Approved by \_\_\_\_\_  
(Signature of provider/practitioner or office manager)