PO Box 9032
2800 Beaumont Avenue
Liberty, TX 77575
936-334-9701

Dear Patient,

You have requested a financial hardship application regarding your ambulance services &/or ambulance transport.

Please review the attached two (2) pages carefully. Complete all applicable areas on the application and be sure to include the ***required*** documentation – applications submitted without proper documentation are automatically disqualified for any financial hardship consideration. To assist in your request, we have also enclosed a postage-paid, self-addressed envelope.

Once your application is received & reviewed, notations will be made in your account and a letter will be sent to the address identified on your application advising of the decision made.

Thank you,

Records Coordinator
Health Claims Plus

888-483-9893

PATIENT FINANCIAL HARDSHIP APPLICATION
PLEASE MAIL BACK TO BILLING OFFICE AT

2800 Beaumont Ave., Ste. E
Liberty, TX 77575

Patient Name: ______________________________ **Balance $**______________________

Ambulance Provider: __________________________ **Pt Account #** ___________________

Our Client abides by the contractual and legal obligations of health benefit plans to collect all charges, co-pay, co-insurance, and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full, **Our Client** adopted the policy of screening requests for discounts, delayed payment plans, or forgiveness of debt based on individual circumstances. In order to do this, we must ask for certain financial information. Please complete the following form to the best of your ability and provide the following supporting documentation: **APPLICATION WILL NOT BE REVIEWED IF WE DO NOT RECEIVE ALL ITEMS REQUESTED AND/OR IF ANY INFORMATION IS OMITTED.**

- A copy of last year's tax return; (MUST BE SIGNED)
- Information from two recent payroll or unemployment benefit payments; for all persons employed in the home
- If income is close to or below poverty level, denial of state medical assistance
- Forms from employers or welfare agencies

All information will be held confidential as per **Our Client's** privacy policy.

Patient Name:________________________**DOB:**______________**SS#:** _______________
Mailing address: ____

Spouse Name:_________________________DOB:_______________SS#: ________________
Guarantor name(s):__________________________Date(s) of service: ___________________________

Number of dependents per guarantor household:________Number in school:______Household total: _____
*E-mail:____Phone:_______________________________________
**By providing this information you give us permission to contact you via unencrypted format.*

Attach copy of Driver's License or identification card for all adults.

Type of Assistance Requested: *(Please check one)*
Reduced deductible [ ]   Reduced co-pay/co-insurance/Non-covered [ ]
Discount of services [ ]   Payment plan [ ]

Employment/Unemployment Information (*for **each adult** family member*):
Employer name: ____
Address:____
Phone: ____
If unemployed please state when employment terminated or if lay-off is temporary, indicate expected duration:
____

Assistance Received: *(please check all applicable)*
State financial assistance [ ] WIC [ ] Food Stamps [ ] Charity Care/other [ ]

Property/Investment : *(please check one)*
Residence [ ] Own [ ] Rent

Please complete the information in the following table based on average income and expenses over the last twelve months. For amounts paid annually, enter annual amount divided by twelve.

Household Financial Information

Monthly Income (after payroll deductions)	$	**Monthly expenses** (not including payroll deductions)	$
Employment		Mortgage/rent	
Unemployment/severance		Auto/transportation	
Self-employment		Non-reimbursed work expenses (e.g., parking, tools)	
Interest/dividends		Insurances (e.g., life, homeowners)	
Pension/disability		Utilities (lights, water, gas, trash)	
Child support/alimony		Medications	
Short-term disability		Childcare	
Long-term disability		Credit cards	
Rental income		Child support/alimony	
Other income:		Personal property taxes (home, auto)	
		Other:	
Total average income	$	**Total average expenses**	$

By my signature below, I certify that this information is true and complete. I grant **Health Claims Plus** permission to verify this information and acknowledge that completion of this form does not guarantee discount, payment plan, or forgiveness of debt.

Signature :____ Date: ________________________

PLEASE DO NOT WRITE BELOW. FOR OFFICE USE ONLY

Ambulance Provider:________________________ **Regarding Patient/Account#:** ____________________________

Received hardship letter from patient on:_______________________________(Letter filed in eBridge System)

Approved for:

Waiver Program/Forgiveness of Debt - {list dollar amount} ______________________________________
- [ ] Account qualifies for Residency Waiver as allowed by CMS
- [ ] Account qualifies for Hardship per current year Poverty Guidelines

Discounted Amount - {list dollar amount or percentage} ____
- [ ] Account granted discounted rate at or above Medicare Allowable Rate for same services
- [ ] Account granted other discount ____

Payment Plan granted - [ ] – First Payment due on: ______________________________
Monthly Payment Amount: ________________________

Approved on:_____/_____/__________ By: ______________________________

This page also serves as notice to Patient/Guarantor of Hardship Application determination. Any questions or concerns should be directed to:

HCP – Billing Office
2800 Beaumont Ave., Ste. E
Liberty, TX 77575
Attn: Patient Financial Services Dept. / Phone: 888-483-9893

Notes: ____