CONNECT HEALTH + WELLNESS

Financial Hardship Process/Application

The patient will need to complete a Financial Hardship Disclosure Form and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1. Documented proof that the patient is at or below 200% of the current federal poverty guidelines (FPG) can include documents such as:

    + W-2 withholding statements
    + Paycheckstubs
    + Income tax return
    + Public Assistance award letter/Pension
    + Social Security award letter
    + Unemployment Benefits

2. Patient has other circumstances that indicate financial hardship. These can be situations such as:
    + Proof of bankruptcy
    + Catastrophic situations (death, disability in family, divorce/separation)
    + Recent loss of employment
    + Homelessness
    + Medical crisis requiring several return visits

Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient. The annual process will also take into consideration seasonal employment and temporary increases and/or decreases to income. Approval of Fee waivers will be performed by the Heath Center Practice Manager.

Any denial of "financial hardship" discount request will be written. All information relating to financial hardship requests will be kept confidential.

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Financial Disclosure Form

Please provide the following information so that we may complete your application:

+ Most recent IRS tax form
+ Check stubs for the past 30 days for all dependents employed in the home
+ Unemployment check stubs for the past 30 days
+ Proof of all other income received for the past 30 days Bank Statements (most current 2 months)

Financial statement (completed and signed)

Patient Name (First Name, Last Name):

_____

Date of Service(s): _____

Name of Responsible Party/Guarantor: _____

Relationship to Patient: _____

Name of Spouse: _____

Responsible Party Mailing Address: _____

City: _____ State: _____

Phone Number: _____

Alternate Phone Number: _____

Number of dependents living in household: _____

Employer Name and Address: _____

_____

Spouse's Employer Name and Address: _____

_____

Other dependent(s) Employer(s) Name and Address: _____

_____

Combined Monthly Family Income & Source:

Monthly Gross Salary	$	Social Security	$
Public Assistance	$	Pension	$
Unemployment	$	Worker's Compensation	$

Provide a brief explanation of your circumstances, for requesting a hardship exception:

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HERIN IS TRUE AND CORRECT. I AUTHORIZE CONNECT HEALTH + WELLNESS TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT. FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

SIGNATURE OF PERSON REQUESTING / DATE:

_____

APPROVED BY / DATE:

_____

Effective Date: 05/02/2019
Next Review Date: 3/24/2023
Approved By: Board of Directors