HARDSHIP WAIVER REQUEST

You have recently received medical services from Business Name. Business Name is required under federal and state laws and agreements with health insurance companies to collect copayments or deductibles from all patients, unless they have secondary coverage under a separate payer, Medicaid or similar programs.

We have previously billed you for the balance you owe after receiving payment from your health insurance, and you have indicated that you do not have secondary coverage. You have also informed us that you are financially unable to pay such amounts.

If you demonstrate a sufficient financial hardship, Business name may be able to waive the balance due. To be considered for a waiver, please fill out the form below. We may contact you or your caregiver for more information if necessary. Completion of this application does not mean your request will be granted.

If you need assistance completing this form, please contact: [billing@domain.com]

PATIENT NAME_____

RESPONSIBLE PARTY (if any): _____

RELATIONSHIP OF RESPONSIBLE PARTY: _____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE_____

EMPLOYMENT STATUS: ☐Employed ☐Unemployed ☐Retired

Due to my current financial hardship, I am unable to pay the copayment, deductible or other medical charges I have been billed by **Business Name**. My financial hardship includes the following (check all that are applicable):

☐ I am a resident of a nursing facility and have no income other than social security income, which is paid to the facility. I do not have other assets that would allow me to pay the patient share amount. I authorize **Business Name** to verify this with the nursing facility where I reside.

☐ My annual household income is less than 200% of the federal poverty guidelines (please see below for current guidelines). I do not have other assets that would allow me to pay the patient share amount. Documentation verifying this is included. Documentation can include, for example, W2 income withholding statements, tax returns, pay check stubs, forms previously completed to obtain Medicaid, unemployment assistance or other state-funded assistance programs. If you have questions about acceptable documentation, please contact Business Name at the number above.

Persons in family/household	200% of 2021 Guidelines
1	$25,760
2	$34,840
3	$43,920
4	$53,000
5	$62,080
6	$71,160
7	$80,240
8	$89,320

** If family size is over 8, please add $4,540 for each additional person.

Poverty guidelines are updated annually. 2021 information obtained from https://www.federalregister.gov/documents/2021/02/01/2021-01969/annual-update-of-the-hhs-poverty-guidelines. If you live in Alaska or Hawaii, please contact us for current applicable rates in those states.

☐ I am otherwise unable to pay the medical bill presented for the following reasons. Please include additional pages or documentation as necessary to allow us to verify any information set forth below:

_____

_____

_____

_____

I HEREBY CERTIFY THAT NO OTHER SOURCE, INCLUDING A PARENT, SPOUSE OR OTHER PERSON OR PROGRAM IS LEGALLY RESPONSIBLE FOR MY BILLS. I CERTIFY THAT THE INFORMATION ON THIS FORM AND SUPPORTING DOCUMENTATION IS TRUE, COMPLETE AND CORRECT. I AUTHORIZE AMT TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING MY FINANCIAL NEED AND ABILITY TO PAY MY MEDICAL BILLS.

SIGNATURE_____

NAME:_____

RELATIONSHIP TO PATIENT (If responsible party):_____

DATE_____

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FOR AMT USE ONLY:

Reviewed By:_____

Date:_____

☐ Approved. Reason:_____

_____

☐ Denied. Reason:_____

_____

HARDSHIP WAIVERS ARE VALID FOR ONE YEAR FROM DATE OF APPROVAL. PATIENT MUST REQUEST AND RECERTIFY FINANCIAL HARDSHIP CONDITIONS FOLLOWING ONE YEAR ANNIVERSARY.