REQUEST FOR HARDSHIP ASSISTANCE

Attached is a Financial Disclosure Form that must be completed in order to determine if you will qualify for Hardship Exemption. The Financial Disclosure Form must be filled out completely and all verification of information attached before a determination can be made regarding final financial status.

The Financial Disclosure will then be reviewed and a determination made, it may help with all or a percentage of the charges incurred if approved.

ERNEST HEALTH will file all insurance, Medicare and Third Party Liability. If you qualify for any State Funded Programs please provide information regarding your application status. The Financial Disclosure and request for hardship is used as a last resource ONLY.

The Financial Disclosure Form will only be in effect for the dates of service that are currently being rendered. (Does not cover indefinitely).

However, based upon future discussions with you regarding your financial situation, the provider may determine that your financial situation has improved enough to remove the Hardship Exemption thereby requiring payment from you for the charges incurred.

THIS APPLICATION DOES NOT APPLY TO THE PHYSICIANS BILLING, YOU MUST CONTACT THE RESPECTIVE PHYSICIAN TO MAKE PAYMENT ARRANGEMENT FOR THEIR BILL.

By signing below and submitting the Financial Disclosure Form you agree to the best of your knowledge that the information contained therein is accurate.

_______________________________________   ______________________
Signature of Applicant   Date

Approved: _________Yes   __________ No

Approved or Non-Approved by:

_______________________________________   ______________________
(CFO and/or CEO)   Date

Amount Approved: __________________   Balance Due (If any):__________________

Financial Disclosure Form

Patient Name ________________________________ Address, City, State, Zip ________________________________

Responsible Party ________________________________ Address, City, State, Zip ________________________________

How long at this address?__________

Monthly Obligations:

Mortgage/Rent $____________ 1st Mortgage Holder______________________ 2nd Mortgage Holder______________

Condo Fee $____________

Avg. Electric/Gas $____________

Avg. Telephone $____________

Avg. Water $____________

Insurance costs $____________

Car Payment $____________

Avg. Food Cost $____________

Credit cards (Itemize by Type:)

_________________________ ___________________________________

_________________________ ___________________________________

_________________________ ___________________________________

_________________________ ___________________________________

Child Support _____________________ Alimony ____________________________

Other Medical/Dental _____________ Other Expenses ______________________________

Total Expenses: ________________

Income:

Your employer: _____________________________Monthly Income: ______________ (Before Taxes)

Spouse's employer: __________________________Monthly Income: ______________ (Before Taxes)

(Attach copies of past two months pay stubs)

Monthly child support/alimony Income: ___________Other Income: __________________

Total Monthly Income:__________

Savings Account Balance: ____________________ Credit Union: ___________________________

Amount patient feels they can pay for services each month $_______________________

The above information is privileged and confidential.

______________________ ____

Date Patient/Responsible Party Signature

Patient's estimated balance after insurance: _____________________ Account is approved for: __________________

Comments: ____

Patient Account Manager: __________________________________ Date: ____________________

Business Office Manager: ___________________________________ Date: ____________________

CFO/CEO ____ Date: ____________________

FINANCIAL ASSESSMENT

Date: ____________________________

Patient Name____________________________ Date of Admission: ________________

Account Number_________________________ Referred From______________________

Admitting Diagnosis: ____

I **Potential Reimbursement**

[ ] Victim of Crime **[ ] Accident/TPL** **[ ] Charity Application**
[ ] Medicare **[ ] Insurance** **[ ] Self-Pay**
[ ] Medicaid **[ ] Worker's Comp** **[ ] Other: ___________**

II **Demographic Information Update**

Address ____
City/State/Zip code ____
Telephone numbers: ____
D.O.B. _______/________/___________ SSN: __________________________

III **Additional Contracts**

Name ______________________________Relationship______________________
Address ____
Telephone numbers ____

IV **Employment Information**

Name of Employer ____
Address ____
Telephone number _________________Date of Employment ________________
Date of Termination ________________

Insurance coverage [ ] Yes [ ] No
If terminated, has coverage continued through COBRA? ____________________

V Insurance Information

List all insurance benefits whether primary secondary or if third party liability.

1. Name of Insurance ______________________________
   Address ______________________________
   ____
   Telephone number ____________Contact ____________

2. Subscriber Name ______________________________
   SSN ______________ Relationship ____________

3. Policy Number/ Group Number ______________________
   Medicare/ Medicaid number ______________________

4. Effective Date ______________________________

5. Pre-Cert Required __________ Pre-existing ____________

VI Victim of Crime

1. Hospitalized due to violent crime (Not involved illegal activity)
   [ ] Yes [ ] No

2. Was Police Report taken? [ ] Yes [ ] No
   City ______________ County ______________

2. Date of Incident ______________________________
   Location ______________________________

VII Third Party Liability/ MVA

1. Date and Time of Accident ______________________
   Location ______________________________
   City and County ______________________________

2. Was the accident the fault of someone other than the patient/RP? _______
   a. Driver: ______________________________
   b. Owner(s): ______________________________
   c. Citation(s) Received: ______________________
   d. Driver's address/ telephone: ______________________
   ____
   e. Owner's Address/ Telephone: ______________________
   ____

3. Insurance coverage: ______________________________
   Policy Number: ______________________________

Insurance company's telephone number: ______________________________

4. Has patient filed suit/planning to sue? [ ] Yes [ ] No

5. Name/ Address/ Telephone of Attorney: ____________________________
____
____

6. Does the patient have Auto Insurance? [ ] Yes [ ] No
A. Name of Insurance company: ____________________________________
B. Policy Number: ____
C. Agent: ____
D. Address/ Telephone: ____

VIII **Workman's Compensation**
Hospitalization due to work related injury or illness

1. Patient still employed by same employer? [ ] Yes [ ] No

2. Name/ Address of Employer:_______________________________________
____

3. Coverage verified? ____

4. Has a Worker's compensation claim been filed? [ ] Yes [ ] No
If Yes, Date Filed: ____

5. Attorney Name/ Address/ Telephone: _________________________________
____
____

IX **Income Information/ Family Unit**
List every member of the family residing in household

Name	Rel	DOB	INCOME	SOURCE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

X **Potential Medicaid Category**
[ ] JUL/ Medicaid
[ ] Food Stamps

[ ] Medicaid only (Pregnant Women and Children)
[ ] Refugees
[ ] Institutional Care (Aged, Blind or Disabled)

[ ] SSI/ Disability
[ ] Potential Aged, Blind or Disabled
[ ] Deceased/ Presumptive SSI eligibility

XI **Complete this section if the patient has applied for medical assistance, or if the patient was previously eligible for medical assistance.**

HSD office location ____
Status of Application ____
Caseworker assigned____
Date of Application ____________________Date of Denial ______________
Reason for Denial ____
Dates of Eligibility ____

NARRATIVE:
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