SEPA Labs
SOUTHEASTERN PATHOLOGY ASSOCIATES

CAP ACCREDITED

FINANCIAL HARDSHIP APPLICATION
FOR WAIVER OF COPAY/DEDUCTIBLE

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. This can include documents such as:
    a. W-2 withholding statements
    b. Pay check 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.

Completion of this application does not mean your request will be granted or that you will be relieve of financial responsibility.

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.

2015 HHS Poverty Guidelines

2015 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in Family Household	Poverty Guideline
1	$ 11,770.00
2	$ 15,930.00
3	$ 20,090.00
4	$ 24,250.00
5	$ 28,410.00
6	$ 32,570.00
7	$ 36,730.00
8	$ 40,890.00

For families/households with more than 8 persons, add $4,160 for each additional person.

Please provide following information so we may complete your application:

- Most recent check stubs in last 30 days (for all persons employed in the home or copy of 1040 orW-2).
- Unemployment check stubs for the past 30 days
- Driver's license or identification card for adults
- Proof of all other income received in the past 30 days
- Proof of all outstanding bills (payment stubs, cancelled checks, etc.)
- Attached financial statement (completely filled out and signed)

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.

PATIENT NAME: _____

DATE(S) OF SERVICE: _____

NAME OF RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT: _____

SPOUSE: _____

TELEPHONE #: _____

ADDRESS: _____

OF FAMILY MEMBERS (LIVING IN HOUSEHOLD: _____

EMPLOYER: _____

ADDRESS: _____

IF UNEMPLOYED, HOW LONG? _____

SPOUSE'S EMPLOYER: _____

ADDRESS: _____

IF SPOUSE UNEMPLOYED, HOW LONG? _____

OTHER FAMILY MEMBER'S EMPLOYER(S): _____

(INCLUDE MEMBER NAME, EMPLOYER & ADDRESS)

_____

_____

_____

_____

_____

_____

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MONTHLY FAMILY INCOME & SOURCE

_____ Patient _____ Spouse _____ Responsible Party ____ Children Working

Monthly Salary (Gross)	$ _____
Public Assistance Benefits	$ _____
Unemployment Benefits	$ _____
Social Security Benefits	$ _____
Workman's Compensation	$ _____
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

FOR MEDICAL OFFICE PERSONNEL USE ONLY

This document was received on _____ (Date)

By: _____ (Name and Title)

Approved by: _____
Signature of provider/practitioner or office manager