FINANCIAL HARDSHIP APPLICATION FOR WAIVER OF COPAY/DEDUCTIBLE

The patient will need to complete a financial disclosure form (see attachment B) and send 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 relieved of financial responsibility.

All information relating to financial hardship requests will be kept confidential.

203 INDIGO DRIVE, BRUNSWICK, GA 31525 | TOLL FREE: (888)261-2671 | PHONE: (912)261-0561-261-2669 | FAX: (912)261-0561
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FINANCIAL DISCLOSURE FORM

Financial Hardship Discount Information Needed. HHS Poverty Guidelines-Used to determine financial hardship based on income.

2018 HHS Poverty Guidelines

2018 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in Family Household	Poverty Guideline
1	$12,140.00
2	$16,460.00
3	$20,780.00
4	$25,100.00
5	$29,420.00
6	$33,740.00
7	$38,060.00
8	$42,380.00

For families/households with more than 8 persons, add $4,320 per year additional member.

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

- Most recent check stub in the last 30 days (**for all person employed in the home or copy of 1040 or W-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 statements (**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, by mail, or fax).

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SEPA Labs
SOUTHEASTERN PATHOLOGY ASSOCIATES

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

FINANCIAL STATEMENT PAYMENT/PLAN/UNCOMPENSATED SERVICES APPLICATION

PATIENT NAME: ____

SSN: __________-_________-______________ DATE OF BIRTH: ____________/_________/______________

TELEPHONE #: ____

ADDRESS: ____

____

DATE(S) OF SERVICE: ____

NAME OF RESPONSIBLE PARTY: ____

RELATIONSHIP TO PATIENT: ____

EMPLOYER: ____

ADDRESS: ____

____

IF UNEMPLOYED, HOW LONG? ____

SPOUSE: ____

SPOUSE'S EMPLOYER: ____

EMPLOYER'S ADDRESS: ____

____

IF SPOUSE IS UMEMPLOYED, HOW LONG? __________________________________

NUMBER OF FAMILY MEMBERS LIVING IN HOUSEHOLD: ________________________

OTHER FAMILY MEMBER'S EMPLOYER(S) (INCLUDE FAMILY MEMBER'S NAME WITH EMPLOYER'S NAME & ADDRESS):

____

____

____

____

____

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 HERE BY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE SOUTHEASTERN PATHOLOGY ASSOCIATES TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

______________________________________ ____________________________
Signature of Person making Request Date

______________________________________ ____________________________
Signature of Person making Request Date

DO NOT WRITE BELOW THIS LINE – FOR OFFICE PERSONNEL USE ONLY

This document was received on_______________ by ____
(Date) **(Name/Title)**

Approved by: ____
(Signature of provider/practitioner or officer manager)

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