PRIORITY HEALTH CARE©
A UNIVERSAL APPROACH TO CARE

REQUEST FOR HARDSHIP WAIVER

If you are experiencing financial hardship, please fill out the following application. Our staff will review it and contact you. You must submit supporting documentation with your request.

Section 1 – Demographics

Patient Name

Mailing Address | **City** | **State** | **Zip Code**

Phone | **Email**

Section 2 – Reason for Hardship Waiver

- ☐ Loss Of Housing
- ☐ Homelessness
- ☐ No Income/Loss of Income
- ☐ Eviction/Foreclosure/Utility Disconnect
- ☐ Caring For an Ill, Disabled or Aging Family Member
- ☐ Emergency Situations
- ☐ Death in the Family
- ☐ Experienced Domestic Abuse
- ☐ Unexpected Medical Expenses
- ☐ Bankruptcy
- ☐ Other: _____

Section 3 – Housing

- ☐ Homeless shelter, street, car, place unfit for human habitation
- ☐ With friends or relatives
- ☐ Apartment or house you own or rent
- ☐ Hotel/Motel
- ☐ Other: _____

Section 4 – Income and Expenses

Do you have health insurance? ☐ YES ☐ NO

Do you receive Public Assistance? ☐ State Financial Assistance ☐ WIC ☐ Food Stamps ☐ CHIP

Can you pay anything towards your medical costs? ☐ YES ☐ NO

Would you like to work out a payment plan with us? ☐ YES ☐ NO

Monthly Income (After Payroll Deductions)		Monthly Expenses (Not Including Payroll Deductions)	
Employment	$	Mortgage/Rent	$
Unemployment/Severance	$	Auto/Transportation	$
Self-Employment	$	Non-Reimbursed Work Expenses (Parking, Tools)	$
Interest/Dividends	$	Insurance (Life, Homeowners)	$
Pension/Disability	$	Utilities (Lights, Water, Gas)	$
Child Support/Alimony	$	Medications	$
Short-Term Disability	$	Childcare	$
Long-Term Disability	$	Credit Cards	$
Rental Income	$	Child Support/Alimony	$
Other Income	$	Personal Property Taxes (Home, Auto)	$
		Other Expenses	$
Total Average Income	**$**	**Total Average Expenses**	**$**

Optional: Please advise of any additional information that you would like us to consider.

Section 5 – Patient Acknowledgements

I declare, under penalty of perjury, that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for discounted services.

I hereby acknowledge that I am applying for assistance under a U.S. HRSA funded program and that Title 18 Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States.

Patient, Parent or Guardian Signature **Date**

Patient Name (Please Print)

FOR OFFICE USE ONLY

Hardship Request	☐	Approved	☐	Denied

Date of Service	Amount
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
Total	**$**

Application Received By (Staff Full Name) **Date**

Chief Executive Officer / Chief Financial Officer **Date**

Patient Notification

Method	Date	Staff Name
☐Verbal ☐Patient Portal ☐Mail		

Revenue Cycle Notification

Method	Date	Staff Name
☐Email		

Revenue Cycle Staff

Date Posted in Practice Management System	
Total Amount Posted in Practice Management System	$
Signature	