STATEMENT OF FINANCIAL HARDSHIP

Sometimes proper medical care may seem to be out of reach due to special financial difficulties or circumstances. In our office, we are concerned that you receive appropriate eye care even if you are experiencing financial problems.

Please let us know about your circumstances. We may be able to set up a flexible payment plan for you or make suitable adjustments to your bill according to the legal guidelines of the Department of Health and Human Services. This information is strictly confidential. Qualification for Financial Hardship Assistance is not guaranteed but we will do all we can to make your eye care affordable.

Name _____ DOB _____

Address _____ Phone _____

_____ _____

Are you receiving any type of assistance from local, county, state, or federal government agencies? If so, describe this assistance: _____

_____

Do you qualify (but have chosen not to receive) assistance from local, county, state or federal government agencies? If so, what type of assistance are you qualified to receive? _____

_____

Do you have other health insurance that covers health related products or services? List the companies and policy numbers: _____

_____

Is a guardian or anyone else legally responsible for your medical bills? Give the name, address, and phone number of this person: _____

_____

Are you employed? Give the name of your employer: _____

How much do you have in savings to which you have immediate access? _____

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How many live in your household? _____

Is there anyone in your household under the age of 19, that you are financially responsible for? Y N

If yes, how many are under the age of 19 in your household? _____

What is your monthly net income for your household: _____

What are your monthly expenses:

Rent or House Payment: _____

Utilities: _____

Car Payment: _____

Other transportation: _____

Food: _____

Medical Bills: _____

Other: _____

Total monthly expenses: _____

In a few words, describe your circumstances and how we can help make your eye care affordable: _____

_____

_____

Please attach copies of the following to this application:

- □ Most current bank statement(s)
- □ W-2 withholding statement(s)
- □ Pay check stub(s)
- □ Income tax return
- □ Proof of bankruptcy settlement
- □ Catastrophic situations paperwork (death or disability in family, divorce)

Income shall be annualized from the date of request based on documentation provided. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income. Any denial of "financial hardship assistance" 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.

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

I certify that the above information on pages 1 and 2 is true and correct and I request Financial Hardship Assistance consideration for my account. I understand that Financial Hardship Assistance is not guaranteed and is regulated by the Department of Health and Human Services.

Beneficiary Signature _____ Date _____

Signature if Beneficiary Unable to Sign _____ Relationship to Beneficiary _____

Reason Beneficiary Unable to Sign _____

FOR OFFICE USE ONLY

Date application received: _____

- □ Discount Approved
  - o Notes: _____

- □ Discount Denied
  - o Reason: _____

Approval Signature _____ Date _____

Title _____