PATIENT FINANCIAL HARDSHIP APPLICATION

Our practice abides by the contractual and legal obligations of health benefit plans to collect charges, co-pays, co-insurance and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full at the time of service, we have adopted a policy of screening requests for discounts, delayed payment plans or forgiveness of debt based on individual circumstances. To do this, we must ask for certain financial information. *All information will be held confidential according to our privacy policy.* Please provide the documents listed below for each adult family member, and complete this form to the best of your ability:

- **A copy of last year's federal tax return;**
- **Copies of the two most recent payroll stubs or unemployment benefit payments;**
- **If income is close to or below the poverty level, documentation that state medical assistance has been applied for and denied.**

Patient Name: ____

Address: ____

Telephone: ____

Responsible Party: ____

Address: ____

Telephone: ____

State financial assistance WIC Food stamps CHIP

Household financial information

Monthly income (after payroll deductions)		Monthly expenses (not including payroll deductions)	
Employment	$	Mortgage/rent	$
Unemployment/severance	$	Auto/transportation	$
Self-employment	$	Non-reimbursed work expenses (e.g., parking, tolls)	$
Interest/dividends	$	Insurance (e.g., life, homeowners)	$
Pension/disability	$	Utilities (e.g., 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	**$**	**Total average expenses**	**$**

If unemployed, please state when employment was terminated. If lay-off is temporary, indicate expected duration:

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Other Comments:

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I certify that the above information is true and accurate and that this application is made to allow Kinex Medical Company to determine my eligibility for reduced out of pocket health care costs. If any of the information that I have given proves to be untrue, Kinex will promptly reevaluate your financial status and take action necessary to collect on your account.

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Signature of patient or parent or legal guardian if patient is a minor Date

Office Use Only

Applicant approved or denied for financial hardship assistance ☐ Approved ☐ Denied

Deductible ________________ COINS ___________________ Other_________________________

Authorized Signature: __________________________________Date_________________________