Arubah

RESTORATION to SOUND HEALTH

FINANCIAL HARDSHIP APPLICATION

FOR PRO BONO OR WAIVER OF COPAY/DEDUCTIBLE

The client will need to complete a financial disclosure form and provide documentation of proof of income. Appropriate financial documentation of financial hardship would be one or more of the following:

1. Documented proof that client is at or below 200% of the current federal poverty guidelines (see attachment for current guidelines). This can include documents such as:

☐ Most recent IRS tax forms (1040 and/or W-2) (Must be signed)
☐ Check stubs for the past 30 days for all persons employed in the home
☐ Unemployment check stubs for the past 30 days
☐ Proof of all other income received in the past 30 days
☐ Proof of all outstanding bills (payment stubs, cancelled checks, etc.)
☐ DSHS Denial letter
☐ Medicaid forms or card

2. Documentation that Client has other circumstances that indicate financial hardship can include::
   a. proof of bankruptcy discharge
   b. proof of other catastrophic situations (death or disability in family, divorce)
   c. any other documentation that shows that client would be unable to pay medical bill and still be able to pay for other basic necessary expenses.

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

☐ Any and all relevant sources from section 1 above.
☐ Driver's license or identification card for adults in the household
☐ 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).

Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the client. 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.

Approval Guidelines

Category #1: At or Below 200% of the Federal Poverty Guidelines

If your income is at or below 200% of the Federal Poverty Guidelines you will automatically be considered for either probono (free) or reduced fee services depending on income, financial situation level of care being provided.

Category #2: Above 200% of the Federal Poverty Guidelines

If your income is above 200% of the Federal Poverty Guidelines we will review your financial situation for a reduced fee depending on income, financial situation and level of care being provided.

FINANCIAL STATEMENT & APPLICATION

CLIENT'S NAME: _____

DATE(S) OF SERVICE: _____

NAME OF RESPONSIBLE PARTY: _____

RELATIONSHIP TO CLIENT: _____

SPOUSES NAME: _____

TELEPHONE: _____

ADDRESS: _____

EMAIL ADDRESS: _____

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD): _____

If the Client is a minor or NOT the responsible party, please complete the information for the responsible party.

CLIENT'S EMPLOYER: _____
CLIENT'S WORK ADDRESS:

_____

IF UNEMPLOYED, HOW LONG?: _____

SPOUSE'S EMPLOYER: _____
SPOUSE'S WORK ADDRESS:

_____

IF UNEMPLOYED, HOW LONG?: _____

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

_____

_____

Other information

If you have a crisis or other situation that you would like to be considered, please describe here. Also attach any supporting documentation.

_____

_____

_____

_____

_____

MONTHLY FAMILY INCOME & SOURCE

Please check each person that you are including in household income.

_____Client _____Spouse _____Responsible Party _____Children Working

Household 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 ARUBAH EMOTIONAL HEALTH SERVICES 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:

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

This document was received on _____ (date)

by _____ (Name/Title)

Approved by _____

(signature of provider/practitioner or office manager)

FINANCIAL GUIDELINES

Financial Hardship Discount Information Needed. U.S. Department of Health & Human Services (HHS) Poverty Guidelines-Used to determine financial hardship based on income.

HHS POVERTY GUIDELINES FOR 2019

The 2019 poverty guidelines are in effect as of January 11, 2019.
Federal Register notice forthcoming. Publication is delayed due to temporary closure of federal offices.

2019 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,420 for each additional person.	
1	$12,490
2	$16,910
3	$21,330
4	$25,750
5	$30,170
6	$34,590
7	$39,010
8	$43,430

PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $5,080 for each additional person.	