PATIENT FINANCIAL HARDSHIP APPLICATION

PATIENT INFORMATION		
Patient Name	Date of Birth	Social Security Number
Home Address (e.g., P.O. Box or Street, City, State, Zip)		
Home Phone	Work Phone	Cell Phone
Number of Persons Living in Household (Including patient): _____ Adults _____ Children		
Name of Person Completing Form (if not pt.)	Relationship to Patient	Telephone

EMPLOYMENT INFORMATION		
	Patient / Guarantor #1	**Spouse / Guarantor #2**
	Employed ☐ Unemployed ☐ Start Date: _____ Retired Start ☐ Date: _____	Employed ☐ Unemployed ☐ Start Date: _____ Retired Start ☐ Date: _____
Employer #1 (Incl. name & address)		
Employer #2 (Incl. name & address)		

FINANCIAL DATA		
INCOME	**Patient/Guarantor #1**	**Spouse/Guarantor #2**
Gross salaries, wages before taxes		
Other Income (list amount/source)		
TOTAL INCOME ALL SOURCES		
ASSETS	**Patient/Guarantor #1**	**Spouse/Guarantor #2**
Cash on hand		
Checking Account(s) balance		
Savings Account(s) balance		
Auto #1 Value - Make, Model, Yr		
Auto #2 Value - Make, Model, Yr		
Boat(s) est. value		
TOTAL ASSETS		
EXPENSES	**Patient/Guarantor #1**	**Spouse/Guarantor #2**
1. Rent/House Payment		

2. Car/Truck Payments		
3. Car Insurance		
4. Utilities (electric/phone/gas/water)		
5. Food/clothing		
6. Credit card payments		
7. Loan payments (Bank, school)		
8. Health/Dental Insurance		
9. Child care		
10. Property Insurance		
11. Medical Fees (Dr, Rx, Hospital)		
12. Other		
13. Other		
TOTAL EXPENSES		

PATIENT ACKNOWLEDGEMENT & SIGNATURE

I acknowledge that the information given herein is true and correct. I authorize JS Therapies to verify any information contained in this document for the sole purpose of assessing financial need.

Signature of Patient or Legal Representative	Date	Relationship to Patient: ☐ Self ☐ Other _____

DOCUMENTATION REQUIREMENTS

Appropriate documentation of financial hardship requires the following:

1. Income and Assets Documentation, including:
– W-2 withholding statements or unemployment check stubs for the past 90 days
– Pay check stubs for the past 90 days for all persons employed in the home
– Income tax return (most recent signed 1040 and/or W-2)
.
2. Evidence of additional circumstances that indicate financial hardship, such as:
– Proof of all outstanding debts or bills (copies of bills, statements; late notices, etc.)
– Proof of bankruptcy settlement (if applicable)
– Catastrophic situations (death or disability in family, divorce) or other documentation which demonstrates the patient would be unable to pay medical bills and still be able to pay for other basic necessary expenses.
3. Please describe other circumstances supporting your financial hardship: _____
_____
_____
_____

JS THERAPIES STAFF USE ONLY

Review Comments

Financial Hardship Verified? ☐ Yes ☐ No

If Yes, percent reduction of charges: _____ Other: _____

Reviewer's Name	Signature	Date

_____

(Date)

To Whom It May Concern,

This letter is to certify that I, _____, parent/guardian of
(Parent or Guardian Name Here)

_____ have significant financial distress and I am unable to make co-
(Insert Childs Name Here)

payment for services rendered by JS Therapies. If the copayment cannot

be waived, _____ will be unable to access medically necessary
(Insert Childs Name Here)

services.

Sincerely,

_____

(PRINT PARENT/GUARDIAN NAME HERE)

_____

(PARENT/GUARDIAN SIGNATURE HERE)

_____

(APPROVAL SIGNATURE. JS THERAPIES USE ONLY)

Financial Hardship Policy

PURPOSE

To outline a policy for patients experiencing financial hardship so they may apply for a discount or waiver of patient's financial responsibility (e.g., copayment, deductible). Whether or not a discount or waiver is granted shall be based on individual assessment of patient's financial circumstances, and assessment of the JS Therapies' legal & contractual obligations to third-party payers.

PROCEDURES

1. Before a discount or waiver is offered to patient, a payment plan will be discussed. Minimum monthly payment: $50.

2. Patients will be reminded that they have a financial obligation to cover any co-payments or deductibles based on their insurance and JS Therapies has a legal obligation to collect those payments based on the contracts that are signed.

3. JS Therapies determines whether the patient is a beneficiary of a private third-party payer plan. If appropriate, JS Therapies determines whether its agreement with the payer prohibits a financial hardship waiver or discount.

4. In order to be considered for a discretionary discount or waiver, documentation of financial hardship must be included in the patient's medical record and a supporting note in the patient's financial account including the following:

   - Patient Financial Assessment Form.

   - One or more of the following:

     a) Documented proof that patient is at or below 200% federal poverty guidelines (free care) or 400% (partial free care) published annually by the U.S. Department of Health and Human Services. Documented proof may include documents such as W-2 withholding statements, unemployment check stubs, paycheck stubs, income tax return (1040), forms from Medicaid or other State-funded medical assistance, forms from employers, and/or welfare or community agencies; or

     b) Documentation that a patient has other circumstances that indicate financial hardship, which may include proof of bankruptcy settlement, catastrophic situations (for example, death or disability in family) or another documentation that shows that patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses.

5. All information relating to financial hardship requests will be kept confidential, except insofar as required by law.