



MEDICAL FINANCIAL HARDSHIP FORM

THE POLICY

Janz Medical Supply has established this policy in an order to maintain consistency in assisting uninsured, indigent and those patients with substantial financial issues who request a reduction or waiver of certain medical charges.

Co-payments, deductibles, or other owed amounts that are the patient's responsibility under the rules of the Medicare, Medicaid or any other governmental or commercial third-party payer may not be waived, except on a case by case basis upon a determination of financial need. Routine waiver of co-payment, deductible, or other owed amounts may be a violation of federal law and is a violation of Janz Medical Supply policy.

DOCUMENTATION

You will be required to provide documentation to Janz Medical Supply in order to assist us in determining a decision regarding reduction or waive of charges owed for services provided by Janz Medical Supply.

- 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.
- Proof of all other income received in the past 90 days.
- Proof of all outstanding debts or bills (copies of bills, statements, late notices).
- Proof of Bankruptcy settlement (if applicable).
- Other (Please describe other circumstances):



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FINANCIAL HARDSHIP APPLICATION

Name: _____ Date of Birth: _____

Phone: _____ Fax: _____

Address: _____ Suite: _____ City: _____ State: _____ Zip: _____

APPLICANT QUESTIONS

1

Are you receiving any type of assistance from local, county, state or federal government agencies? If yes, what types of assistance are you qualified to receive?

- No
 Yes – _____

2

If not, do you qualify for assistance from local, county, state or federal government agencies? If so, what types of assistance are you qualified to receive?

3

Do you have other health insurance that covers health related products or services? If "Yes", please list the companies and policy numbers.

- No
 Yes – _____

4

Is a guardian or anyone else legally responsible for your medical bills? If "Yes", please list name, address and phone numbers of this person:

- No
 Yes – _____

5

Are you employed? If "Yes", please provide employer's name, address and phone number:

- No
 Yes – _____

What is your pay period?

- Weekly
 Bi-weekly
 1st & 15th
 Other: _____

What is your Gross per pay period? _____

What is your Net per pay period? _____

6

Do you own your home?

- No
 Yes

Are you still making payments on it?

- No
 Yes – Monthly payments are: _____



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APPLICANT QUESTIONS - (CONTINUED)

7

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

8

What are your monthly net income from?

Your Employment: _____

Social Security: _____

Retirement: _____

Investments: _____

Other: _____

Total Monthly Income: _____

9

What are your monthly expenses?

Rent/House payment _____

Utilities: _____

Car payment: _____

Other Transportation: _____

Food: _____

Medical bills: _____

Other: _____

Total Monthly Expenses: _____

APPLICANT ACKNOWLEDGMENT AND SIGNATURE

I certify that the above information is true and correct. I request that you consider me for reduction or waiver of charges/balance.

Signature

Date

Signature of representative if patient is unable to sign

Relationship to Patient

Reason patient is unable to sign

FOR OFFICE USE ONLY

Reduction of Charges/Balance: Approved Denied

Waiver of Charges/Balance: Approved Denied

% of Reduction: _____

% of Waived: _____

Reduction in effect for date(s) ONLY: _____

Waiver in effect for date(s) ONLY: _____