CONFIDENTIAL FINANCIAL HARDSHIP WORKSHEET
Valid for a Maximum of 12 Months (Re-application is Necessary)

Patient Name: _____
Last *First* *M.I.*

Patient Address: _____

_____

Responsible Party (if other than patient): _____

Customer Equipment Type:
(check all that apply)

❑ Oxygen ❑ Infusion Therapy
❑ Other Respiratory ❑ DME

FAMILY SIZE
Number in Household _____
Other Dependents _____
(proof ofincome for all listed is required)

What is your current insurance information? Please list <u>all</u> medical insurance plans that you carry.

Primary: **Secondary:** **Other:**

Have you applied for Medicaid? Y or N If you answered **Yes**, please enter the estimated date your application for Medicaid will be processed _____.

INCOME
Please complete the financial information requested below. All information provided is strictly confidential and will be used only for purposes of determining financial hardship. In addition to the information requested below, you ***must*** provide a copy of the last W-2's and/or copies of the last 3 paystubs for proof ofincome for ***each member listed in the household count above***. Without receipt of these documents, we will not be able to review your request for financial hardship**.** *Lincare reserves the right to perform upfront and/or intermittent verification ofincome and credit through an independent source.*

Monthly Net Income *(After payroll deductions)*		**Monthly Expenses** *(Do not include payroll deductions)*	
Employment	$	Mortgage/rent	$
Unemployment/severance	$	Auto/transportation	$
Self-employment	$	Non-reimbursed work expenses (e.g., parking, tools)	$
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	$
State/Government Financial Aid:	$	Personal property taxes (home, auto)	$
Other income: (List source)	$	Other expenses: (List name)	$
Other income: (List source)	$	Other expenses: (List name)	$
Total income	$	Total expenses	$

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Patient Name: _____

Last *First* *M.I.*

I certify that the above information is true and accurate and that this application is made to enable the medical supplier to judge my eligibility for reduced out-of-pocket medical expenses. The amount of financial assistance the medical supplier may grant will be determined based on the financial information and backup provided as well as the patient's individual situation. The medical supplier will inform you of the amount of financial assistance available. Please note that no more than 70% of your financial responsibility will be eligible for financial assistance, and any financial assistance granted will remain in effect for only 12 months. A new confidential financial worksheet must be filed with the medical supplier every 12 months.

I acknowledge that in addition to the financial assistance granted by the medical supplier, I will be responsible to pay not only my annual insurance and/or Medicare deductible but also other charges resulting from services provided to me-the patient.

Customer Signature: _____ Date: _____

FOR INTERNAL USE ONLY:
Account approved for _____% financial waiver of coinsurance.

Patient was previously approved for financial waiver of _____%, but has an open balance of $_____.

Location code: 90- ____-_____-____ Primary PR _____ Secondary PR _____

Are there other observations or considerations that would support the patient's declaration of financial hardship?
_____
_____
_____

Employee Signature: _____

Center Manager Approval: _____ Date: _____

Area Manager Approval: _____ Date: _____

VP Approval: _____ Date: _____

RBCO Approval (Name/Title): _____ Date: _____