**FINANCIAL HARDSHIP WAIVER**

APPLICATION FOR MEDICARE CO-INSURANCE/CO-PAY WAIVER

For All Payers (Medicare and Commercial)

**Patients with Commercial (Private) Insurance**

In addition to relevant laws, private payor contracts generally require that the provider collect copays and deductibles. Failure to do so without the payor’s express approval would violate the contract terms and could result in claims for breach of contract or repayment. The health care provider may, however, elect to waive all or a portion of the Medicare patient responsibility if the health care provider determines that the beneficiary does not have the ability to pay. To assist us in determining if you have the ability to pay, please answer the following questions:

**Medicare:**

Medicare law requires a health care provider that accepts an assignment for services billed to the Medicare program, to bill the beneficiary for their portion of the cost of these services. The health care provider may, however, elect to waive all or a portion of the Medicare patient responsibility if the health care provider determines that the beneficiary does not have the ability to pay. To assist us in determining if you have the ability to pay, please answer the following questions:

First Name (Required): Last Name (Required):

Date of Birth *(Required)*:



Street Address *(Required)*:



Street Address 2:

City (Required): State (Required):



Zip Code (Required):



Medicare/Insurance ID Number:

Email (Required):

Net Monthly Income from All Sources: Family Size:

1. Are you receiving any type of financial assistance from local, county, state, or federal government agencies? *(Required)*

Yes No

If yes, describe this assistance:



1. Do you have other health insurance in addition to Medicare or the Private Insurance we have on file, that covers health related products or services? *(Required)*

Yes No

If yes, give the name, address, and phone number of coverage:



1. Is a trust, guardian or anyone else legally responsible for your medical bills? *(Required)*

Yes No

If yes, give the name, address, and phone number of this person:



MORE QUESTIONS ON THE FOLLOWING PAGE:

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APPLICATION FOR MEDICARE CO-INSURANCE/CO-PAY WAIVER (CONTINUED)

1. Do you own your own home? *(Required)*

Yes No

1. How much do you have in savings to which you have immediate access? *(Required)*



POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES & THE DISTRICT OF COLUMBIA

[Source: HHS Poverty Guidelines, Federal Register, January 12, 2022.]

|  |  |  |
| --- | --- | --- |
| SIZE OF FAMILY UNIT  | POVERTY GUIDELINE  | 200% OF POVERTY GUIDELINE  |
| 1  | $13,590  | $27,180  |
| 2  | $18,310  | $36,620  |
| 3  | $23,030  | $46,060  |
| 4  | $27,750  | $55,500  |
| 5  | $32,470  | $64,940  |
| 6  | $37,190  | $74,380  |

  I hereby certify that the information provided above is accurate and complete to the best of my knowledge. I formally request that all or a portion of my patient responsibility be waived based on financial hardship. I understand that I may be required to submit supporting documentation, such as pay stubs, bank statements, or other relevant materials, to verify my inability to pay.

 I acknowledge that I have carefully reviewed the terms and conditions of the **Financial Hardship Waiver** offered by **MVM Health** and I consent to the evaluation of my financial status in accordance with the clinic’s policies.

Signature Date