Financial Hardship Agreement

By virtue of my signature set forth below, I hereby request that my doctor and institutional provider reduce their usual and customary charges in order to allow me to receive care required by my current health care condition.

I represent and warrant that my financial status is such that I would be unable to receive diagnostic and treatment services if usual and customary charges were applied to the services required by my condition.

I recognize and acknowledge that this Agreement to reduce usual and customary charges is undertaken for my benefit, that this is dependent on my financial status as of the date of this Agreement, that it will result in a fee arrangement distinct from the one usually in place for the services in question and that the arrangement represents a confidential agreement entered into by the parties for the sole and exclusive benefit.

In light of the foregoing, I hereby agree to the following:

1. I will not seek reimbursement for the services rendered to me under this arrangement from any insurance company, employer, welfare program, government entitlement program (Medicare or Medicaid), Workers' Compensation program or other third-party payor.
2. If any third party payor responsible for all or part of the payment due as a result of services rendered under this Agreement contacts me, I will notify such payor of this arrangement and the reduced fees achieved as a result of the Agreement.
3. If the financial circumstances which cause me to qualify for financial hardship under this Agreement change, I will immediately notify my doctor and institutional provider in order to allow them to determine whether my financial status will then allow me to pay usual and customary charges for the services which I receive from that date forward.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

Witness Signature: _____

Date Signed: _____

Financial Hardship Application

The patient will need to complete a financial disclosure form (see attachment B) and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1) Documented proof that patient is at or below 200% of the current federal poverty guidelines (see attachment B for 2008 guidelines). This can include documents such as

    a. W-2 withholding statements
    b. Pay check stubs
    c. Income tax return
    d. Forms from Medicaid or other State-funded medical assistance
    e. Forms from employers or welfare agencies.

2) Patient has other circumstances that indicate financial hardship. These can be situations such as:

    a. proof of bankruptcy settlement
    b. catastrophic situations (death or disability in family, divorce)
    c. or other documentation that shows that patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses.

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

All information relating to financial hardship requests will be kept confidential.

OIG Special Fraud Alert (1994). OIG Advisory Opinion 97-4. Federal Register, Vol 65, No. 81, 4-26-00 pages 24401-2440742 CFR, section 1001.952 (k)HIPAA, section 231(h), section 1128A42 USC, Section 1320a-7aBBA, section 4331 False Claims Act, Public Law 104-191, Kennedy v Connecticut General Life Ins. Co (Case Law) 924 F.2d 698 (7th Cir. 1991) Managed Care Contracts

Attachment B

Financial Disclosure Form

Financial Hardship Discount Information Needed. HHS Poverty Guidelines-Used to determine financial hardship based on income.

2016 FEDERAL POVERTY GUIDELINES				
Tax Credit Amounts >>>		$1,000	$700	$500
Household Size	Poverty Limit	140%	170%	200%
1	$11,770	$16,478	$20,009	$23,540
2	$15,930	$22,302	$27,081	$31,860
3	$20,090	$28,126	$34,153	$40,180
4	$24,250	$33,950	$41,225	$48,500
For Households greater than 5 members, please contact the Tax Assessor for Income Limits				

Please provide following information so we may complete your application:

- ❑ 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.
- ❑ Drivers license or identification card for adults.
- ❑ 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
- ❑ Attached financial statement (completely filled out and signe)

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).

Financial statement payment plan/uncompensated services application.

PATIENT NAME: _____

DATE(S) OF SERVICE:

NAME OF RESPONSIBLE PARTY:_____

RELATIONSHIP TO PATIENT:_____

SPOUSE: _____

TELEPHONE: _____

ADDRESS:_____

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD):_____

EMPLOYER:_____

ADDRESS:_____

IF UNEMPLOYED, HOW LONG?:_____

SPOUSE'S EMPLOYER:_____

ADDRESS:_____

IF UNEMPLOYED, HOW LONG?:_____

OTHER FAMILY MEMBER'S EMPLOYER(S):

(INCLUDE MEMBER NAME, EMPLOYER, & ADDRESS

_____

_____

_____

MONTHLY FAMILY INCOME & SOURCE

__Patient __Spouse __Responsible Party __Children Working

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 [YOUR COMPANY] 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 IN BOX – FOR OFFICE PERSONNEL USE ONLY

This document was received on _____ (date)

by _____(Name/Title)

Approved by _____
(signature of provider/practitioner or office manager)

Attachment B

Financial Disclosure Form

Financial Hardship Discount Information Needed. HHS Poverty Guidelines-Used to determine financial hardship based on income.

2022 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	Poverty guideline
1	$13,590
2	$18,310
3	$23,030
4	$27,750
5	$32,470
6	$37,190
7	$41,910
8	$46,630
For families/households with more than 8 persons, add $4,720 for each additional person.	

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- ❑ Unemployment check stubs for the past 30 days.
- ❑ Drivers license or identification card for adults.
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Acupuncture Center
OF SOUTHERN NH, LLC

Vicki Irwin, Lic. Ac.

155 Main Dunstable Road, Suite 135
Nashua, NH 03060

Financial Hardship Sliding Scale

My usual fee for initial evaluation visit is $70-90 and for follow up visits is $75-125. The following sliding scale will apply for qualifying applicants:

1. **Income equivalent to 100% or less of poverty level pays $25 for the initial visit, $40 for follow up visits.**
2. **Income equivalent to 101% to 150% of poverty level pays $25 for the initial visit, $45 for follow up visits.**
3. **Income equivalent to 151-200% of poverty level pays $25 for the initial visit, $50 for follow up visits.**

Revised 06/23/2022