

PATIENT FINANCIAL HARDSHIP APPLICATION

Metropolitan Pediatrics, LLC

<i>Metropolitan Pediatrics, LLC</i>			
Name		Date of Birth	Social Security Number
Home Address			
Home Phone		Work Phone	Cell Phone
Number of Members Living in Household: _____ Adults _____ Children			
Name of Person Completing Form (if not pt.)		Relationship to Patient	Telephone
Patient / Guarantor #1		Spouse / Guarantor #2	Guarantor #3
Currently unemployed? If yes, how long? _____		Currently unemployed? If yes, how long? _____	Currently unemployed? If yes, how long? _____
Employer #1 (Incl. address, contact, and phone)			
Employer #2 (Incl. address, contact, and phone)			
Employer #3 (Incl. address, contact, and phone)			
TOTAL HOUSEHOLD INCOME	Patient / Guarantor #1	Spouse / Guarantor #2	Guarantor #3
1. Gross salaries, wages before taxes			
2. Business Income			
3. Rental Income			
4. Investment Income			
5. Income from Estates/Trusts			
6. Alimony Income			
7. Child Support			
8. Social Security			
9. Aid to Dependent Children			
10. Public Assistance Income			
11. SSI/Disability			
12. Pension			
13. Other Income (list amount/source)			
14. Other Income (list amount/source)			
TOTAL INCOME ALL SOURCES			
TOTAL HOUSEHOLD ASSETS	Patient / Guarantor #1	Spouse / Guarantor #2	Guarantor #3
1. Cash on hand			
2. Checking Account(s) balance			
3. Savings Account(s) balance			
4. Mutual Funds current value			
5. Stocks current value			
6. Bond(s) current value			
7. Home - assessed value			
8. Rental property assessed value			
9. Business property assessed value			
10. Auto #1 Value - Make, Model, Yr			
11. Auto #2 Value - Make, Model, Yr			
12. Auto #3 Value - Make, Model, Yr			

13. Recreational Vehicle(s) est. value
14. Boat(s) est. value
15. Cash value of life insurance
16. Cash value of pension
TOTAL ASSETS

TOTAL HOUSEHOLD EXPENSES	Patient / Guarantor #1	Spouse / Guarantor #2	Guarantor #3
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. Child Support Payments			
11. Life Insurance			
12. Property Insurance			
13. Property Tax			
14. Medical Fees (Dr, Rx, Hospital)			
15. Other			
16. Other			
TOTAL EXPENSES			

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)
 - Proof of all other income received in the past 90 days
 - Application Forms from Medicaid or other State-funded medical assistance program
 - Forms from employers or welfare agencies.

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 patient indigent circumstances: _____

4. Proposed monthly payments: _____

I hereby acknowledge that the information given herein is true and correct. I authorize Metropolitan Pediatrics, LLC 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 _____
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