



REQUEST FOR HARDSHIP ASSISTANCE

Attached is a Financial Disclosure Form that must be completed in order to determine if you will qualify for Hardship Exemption. The Financial Disclosure Form must be filled out completely and all verification of information attached before a determination can be made regarding final financial status.

The Financial Disclosure will then be reviewed and a determination made, it may help with all or a percentage of the charges incurred if approved.

ERNEST HEALTH will file all insurance, Medicare and Third Party Liability. If you qualify for any State Funded Programs please provide information regarding your application status. The Financial Disclosure and request for hardship is used as a last resource ONLY.

The Financial Disclosure Form will only be in effect for the dates of service that are currently being rendered. (Does not cover indefinitely).

However, based upon future discussions with you regarding your financial situation, the provider may determine that your financial situation has improved enough to remove the Hardship Exemption thereby requiring payment from you for the charges incurred.

THIS APPLICATION DOES NOT APPLY TO THE PHYSICIANS BILLING, YOU MUST CONTACT THE RESPECTIVE PHYSICIAN TO MAKE PAYMENT ARRANGEMENT FOR THEIR BILL.

By signing below and submitting the Financial Disclosure Form you agree to the best of your knowledge that the information contained therein is accurate.

Signature of Applicant

Date

Approved: _____ Yes

_____ No

Approved or Non-Approved by:

(CFO and/or CEO)

Date

Amount Approved: _____ Balance Due (If any): _____



ERNEST
HEALTH, INC.

Financial Disclosure Form

Patient Name

Address, City, State, Zip

Responsible Party

Address, City, State, Zip

How long at this address? _____

Monthly Obligations:

Mortgage/Rent	\$ _____	1 st Mortgage Holder	_____	2 nd Mortgage Holder	_____
Condo Fee	\$ _____				
Avg. Electric/Gas	\$ _____				
Avg. Telephone	\$ _____				
Avg. Water	\$ _____				
Insurance costs	\$ _____				
Car Payment	\$ _____				
Avg. Food Cost	\$ _____				
Credit cards (Itemize by Type:)					

_____	_____
_____	_____
_____	_____
_____	_____

Child Support _____
Other Medical/Dental _____

Alimony _____
Other Expenses _____

Total Expenses: _____

Income:

Your employer: _____ Monthly Income: _____ (Before Taxes)
 Spouse's employer: _____ Monthly Income: _____ (Before Taxes)
 (Attach copies of past two months pay stubs)
 Monthly child support/alimony Income: _____ Other Income: _____

Total Monthly Income: _____

Savings Account Balance: _____ Credit Union: _____

Amount patient feels they can pay for services each month \$ _____

The above information is privileged and confidential.

Date

Patient/Responsible Party Signature

Patient's estimated balance after insurance: _____ Account is approved for: _____

Comments: _____

Patient Account Manager: _____ Date: _____

Business Office Manager: _____ Date: _____

CFO/CEO _____ Date: _____



ERNEST HEALTH, INC.

FINANCIAL ASSESSMENT

Date: _____

Patient Name _____ Date of Admission: _____

Account Number _____ Referred From _____

Admitting Diagnosis: _____

I Potential Reimbursement

Victim of Crime Accident/TPL Charity Application
 Medicare Insurance Self-Pay
 Medicaid Worker's Comp Other: _____

II Demographic Information Update

Address _____
City/State/Zip code _____
Telephone numbers: _____
D.O.B. ____/____/____ SSN: _____

III Additional Contracts

Name _____ Relationship _____
Address _____
Telephone numbers _____

IV Employment Information

Name of Employer _____
Address _____
Telephone number _____ Date of Employment _____
Date of Termination _____

Insurance coverage Yes No
If terminated, has coverage continued through COBRA? _____

V Insurance Information

List all insurance benefits whether primary secondary or if third party liability.

1. Name of Insurance _____
Address _____
Telephone number _____ Contact _____
2. Subscriber Name _____
SSN _____ Relationship _____
3. Policy Number/ Group Number _____
Medicare/ Medicaid number _____
4. Effective Date _____
5. Pre-Cert Required _____ Pre-existing _____

VI Victim of Crime

1. Hospitalized due to violent crime (Not involved illegal activity)
 Yes No
2. Was Police Report taken? Yes No
City _____ County _____
2. Date of Incident _____
Location _____

VII Third Party Liability/ MVA

1. Date and Time of Accident _____
Location _____
City and County _____
2. Was the accident the fault of someone other than the patient/RP? _____
 - a. Driver: _____
 - b. Owner(s): _____
 - c. Citation(s) Received: _____
 - d. Driver's address/ telephone: _____
 - e. Owner's Address/ Telephone: _____
3. Insurance coverage: _____
Policy Number: _____

Insurance company's telephone number: _____

4. Has patient filed suit/planning to sue? [] Yes [] No

5. Name/ Address/ Telephone of Attorney: _____

6. Does the patient have Auto Insurance? [] Yes [] No

A. Name of Insurance company: _____

B. Policy Number: _____

C. Agent: _____

D. Address/ Telephone: _____

VIII Workman's Compensation

Hospitalization due to work related injury or illness

1. Patient still employed by same employer? [] Yes [] No

2. Name/ Address of Employer: _____

3. Coverage verified? _____

4. Has a Worker's compensation claim been filed? [] Yes [] No

If Yes, Date Filed: _____

5. Attorney Name/ Address/ Telephone: _____

IX Income Information/ Family Unit

List every member of the family residing in household

Name	Rel	DOB	INCOME	SOURCE
------	-----	-----	--------	--------

1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____

X Potential Medicaid Category

[] JUL/ Medicaid

[] Food Stamps

