



Financial Hardship Application

Patient Name:	Patient SS#	D.O.B.	Date:
Patient Address:		Patient Phone:	
Name of person completing this application if other than patient named above: Relationship to Patient:		Phone:	
Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name and address of employer _____	If yes, phone# & name of contact _____	
If no, how long unemployed:	_____	_____	
Number of family members living in household:			

A. Provide documented proof that patient is at or below the 135% of current federal poverty guidelines. Appropriate documentation of financial hardship may include but is not limited to one or more of the following:

- W-2 withholding statement Unemployment check stubs for past 90 days
- Income tax return (most recent signed 1040 and/or W2) Proof of all other income received in past 90 days
- Application forms from Medicaid or other state funded medical assistance program
- Forms from employers or welfare agencies

B. Provide proof of financial hardship from circumstances such as:

- Proof of all outstanding bills and debts Proof of bankruptcy settlement
- Catastrophic situations (death, disability in family, divorce)
- Other documentation that demonstrates patient's inability to pay medical bills and still be able to pay for basic necessities.

C. Describe financial hardship circumstances: _____

Monthly Family Income and Source				Average Monthly Family Expenses	
	Patient	Spouse	Dependents		Amount
Monthly Salary Gross				Rent/Mortgage	
Public Assistance				Phone/Internet	
Unemployment				Cable	
Social Security Benefits				Electricity	
Workman's Compensation				Car Payment	
Child Support				House Insurance	
Other (alimony)				Car Insurance	
Other (retirement pension)				Gas/Transportation	
Other				Credit Cards/Loans	
				Food	
				Medicine	
				Other	
Total Family Income				Total Expenses	

I hereby acknowledge that the information given herein is true and correct. I authorize Millennium Physician Group to verify any information contained in this document for the sole purpose of assessing financial need.

Signature of Person Making Request: _____ **Date:** _____

Return all forms and required documentation (in person or by mail) to:
Millennium Physician Group Business Services Dept.
2675 Winkler Ave., 2nd FL, Fort Myers, FL 33901 Phone: 877-856-3774
 All information pertaining to financial hardship requests will be kept confidential.