MILLENNIUM PHYSICIAN GROUP
Your Connection to a Healthier Life

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? □ Yes □ No If no, how long unemployed:	If yes, name and address of employer _____ _____	If yes, phone# & name of contact _____ _____	
Number of family members living in household:			

A. Provide documented proof that patient is at or below the 138% 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
□ Income tax return (most recent signed 1040 and/or W2)
□ Application forms from Medicaid or other state funded medical assistance program
□ Forms from employers or welfare agencies
□ Unemployment check stubs for past 90 days
□ Proof of all other income received in past 90 days

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

□ Proof of all outstanding bills and debts
□ 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.
□ Proof of bankruptcy settlement

C. Describe financial hardship circumstances: _____
_____
_____

Monthly Family Income and Source			
	Patient	Spouse	Dependents
Monthly Salary Gross			
Public Assistance			
Unemployment			
Social Security Benefits			
Workman's Compensation			
Child Support			
Other (alimony)			
Other (retirement pension)			
Other			
Total Family Income			

Average Monthly Family Expenses	
	Amount
Rent/Mortgage	
Phone/Internet	
Cable	
Electricity	
Car Payment	
House Insurance	
Car Insurance	
Gas/Transportation	
Credit Cards/Loans	
Food	
Medicine	
Other	
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.