TEXAS PHYSICAL THERAPY SPECIALISTS

PATIENT FINANCIAL HARDSHIP APPLICATION

TexPTS locations abide by the contractual and legal obligations of health benefit plans to collect charges, co-pays, co-insurance and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full at the time of service, we have adopted a policy of screening requests for discounts, delayed payment plans or forgiveness of debt based on individual circumstances. To do this, we must ask for certain financial information. All information will be held confidential according to our privacy policy. Please provide the documents listed below for each adult family member, and complete this form to the best of your ability:

- A copy of last year's federal tax return;
- Copies of the two most recent payroll stubs or unemployment benefit payments;
- If income is close to or below the poverty level, documentation that state medical assistance has been applied for and denied

Patient name: _____ Patient date of birth: _____

Your name: _____ Name of other responsible party: _____

Number of dependents in household: _____ Number in school: _____

Phone: _____

E-mail: _____

TYPE OF ASSISTANCE REQUESTED

☐ Reduced Deductible ☐ Reduced co-pay/co-insurance ☐ Discounted cash services

☐ Payment Plan ☐ Debt forgiveness

EMPLOYMENT/UNEMPLOYMENT/RETIREMENT INFORMATION (FOR EACH ADULT FAMILY MEMBER)

Name: _____ Employer: _____

Address: _____

Phone: _____

Employer: _____

Address: _____

Phone: _____

Name: _____ Employer: _____

Address: _____

Phone: _____

Employer: _____

Address: _____

Phone: _____

If unemployed, please state when employment was terminated. If lay-off is temporary, indicate expected duration:

_____

_____

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ASSISTANCE RECEIVED

☐ State financial assistance ☐ WIC ☐ Food Stamps ☐ CHIP

PROPERT/INVESTMENT VALUE

	Address or Description	Value
Home		$
Other real estate owned		$
Land		$
Business		$
Livestock		$
Savings/stocks/ bonds		$
Other investments		$

Notes: _____

_____

Monthly income (after payroll deductions)		Monthly expenses (not including payroll deductions)	
Employment	$	Mortage/rent	$
Unemployment/severance	$	Auto/transportation	$
Self-employment	$	Non-reimbursed work expenses (e.g., parking, tools)	$
Interest/dividends	$	Insurance (e.g., life, homeowners)	$
Pension/disability	$	Utilities (e.g., lights, water, gas)	$
Child support/alimony	$	Medications	$

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Short-term disability	$	Childcare	$
Long-term disability	$	Credit cards	$
Rental income	$	Child support/alimony	$
Other income	$	Personal property taxes (home, auto)	$
		Other expenses	$
Total Average Income	**$**	**Total Average Expenses**	

By my signature below, I certify that this information is true and complete. I grant this office permission to verify the information, and I acknowledge that completion of this form does not guarantee discount, payment plan or forgiveness of debt.

Signed:_____ Date: _____

Reviewed by: _____ Date: _____

Approved for:_____

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APPLICATION FOR MEDICARE CO-INSURANCE/CO-PAY WAIVER

Medicare law requires a health care provider that accepts an assignment for services billed to the Medicare program, to bill the beneficiary for their portion of the cost of these services. The health care provider may, however, elect to waive all or a portion of the Medicare patient responsibility if the health care provider determines that the beneficiary does not have the ability to pay. In order to assist us in determining if you have the ability to pay, please answer the following questions:

Name:_____ Phone Number:_____

Address:_____ Date of Birth: ___/___/___ Sex:_____

_____ Medicare #:_____

1) Are you receiving any type of assistance from local, county, state, or federal government agencies? If so, describe this assistance:_____

_____

2) If not, do you qualify for assistance from local, county, state, or federal government agencies? If so, what type of assistance are you qualified to receive?_____

_____

3) Do you have other health insurance that covers health related products or services?

☐ Yes ☐ No ☐ If yes, give the name, address and phone number of this person.

_____

_____

4) Is a guardian or anyone else legally responsible for your medical bills?

☐ Yes ☐ No ☐ If yes, give the name, address and phone number of this person.

_____

_____

5) Are you employed? ☐ Yes ☐ No

If Yes, what is your pay period (e.g., weekly, every other week, 1st & 15th)?_____

How much do you gross per pay period?_____

How much do you net per pay period?_____

6) Do you own your own home? ☐ Yes ☐ No

If Yes, are you still making payments on it? ☐ Yes ☐ No

How much is each monthly payment?_____

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7) How much do you have in savings to which you have immediate access?
(Does not include qualified retirements): _____

8) What is your monthly net income from:
Your Employment: _____
Social Security: _____
Retirement: _____
Investments: _____
Other: _____

9) What are your monthly expense:
Rent or House Payment: _____
Utilites: _____
Car Payment: _____
Other Transportation: _____
Food: _____
Medical Bills: _____
Other: _____
Total Monthly Expenses: $ _____

I certify that the above information is true and correct and I request that the Medicare patient responsibility or a portion of it be waived. I agree to provide proof of all information above in the form of pay stubs, bank statements or any is necessary documents to prove inability to pay.

_____ / /
BENEFICIARY SIGNATURE DATE:

_____ _____
SIGNATURE IF BENEFICIARY IS UNABLE TO SIGN RELATIONSHIP TO BENEFICIARY

_____
REASON BENEFICIARY IS UNABLE TO SIGN

****

FOR OFFICE USE ONLY

/ /
DATE:

WAIVER APPROVED ☐
WAIVER DENIED ☐

Level of approval
25% 50%
75% 100%

_____
APPROVAL SIGNATURE

_____ / /
TITLE DATE:

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SLIDING FEE SCALE 2017

Annual Yearly Income

Family Size	Pays 0% of Patient Responsibility	Pays 25% of Patient Responsibility	Pays 50% of Ptient Responsibility	Pays 75% of Patient Responsbility	Pays 100% of Patient Responsibility
	Category A	Category B	Category C	Category D	Category E
	up to 100% of FPL 2017	up to 125% of FPL 2017	up to 150% of FLP 2017	up to 175% of FPL 2017	up to 200% of FPL 2017
1	0 to $11,880	$11,881 to $14,850	$14,851 to $17,820	$17,821 to $20,790	$20,791 to $23,760
2	0 to $16,020	$16,021 to $20,025	$20,026 to $24,030	$24,031 to $28,035	$28,036 to $32,040
3	0 to $20,160	$20,161 to $25,200	$25,201 to $30,240	$30,241 to $35,280	$35,281 to $40,320
4	0 to $24,300	$24,201 to $30,375	$30,376 to $36,450	$36,451 to $42,525	$42,526 to $48,600
5	0 to $28,440	$28,441 to $35,550	$35,551 to $42,660	$42,661 to $49,770	$49,771 to $56,880
6	0 to $32,580	$32,581 to $40,725	$40,725 to $48,870	$48,871 to $57,015	$57,016 to $65,160
7	0 to $36,730	$36,731 to $45,913	$45,914 to $55,095	$55,096 to $64,277	$64,278 to $73,460
8	0 to $40,890	$40.891 to $51,113	$51,113 to $61,335	$61,336 to $71,557	$71,558 to $81,780