Upper Chesapeake Medical Services & Affiliates (Physician Practices)

Request for Financial Hardship/Charity Adjustment

DATE: _____

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE # (_____) _____ CELL PHONE #: (_____) _____

EMPLOYMENT STATUS:

( ) EMPLOYED ( ) UNEMPLOYED ( ) RETIRED ( ) DISABILITY ( ) SOCIAL SECURITY

IF EMPLOYED –

NUMBER OF HOURS WORKED PER WEEK: _____ SALARY: _____ (HRLY/WKLY/ANNUALLY)

TOTAL FAMILY MEMBERS IN HOUSEHOLD: _____

FAMILY (ALL HOUSEHOLD MEMBERS) INCOME: _____ (WEEKLY/MONTHLY/ANNUALLY)

PLEASE PROVIDE AN EXPLANATION AS TO WHY YOU ARE UNABLE TO PAY YOUR MEDICAL BILLS:

_____

_____

_____

THE FOLLOWING DOCUMENTATION IS REQUIRED:

IF EMPLOYED, PLEASE SUBMIT ONE OF THE FOLLOWING: 1040, W2, 2 CURRENT PAY STUBS, WRITTEN STATEMENT FROM YOUR EMPLOYER.

IF UN-EMPLOYED, PLEASE SUBMIT ONE OF THE FOLLOWING: PROOF OF DISABILITY/SOCAIL SECURITY/SSI BENEFITS, PUBLIC ASSISTANCE CHECK, COMPLETED ZERO INCOME FORM, LETTER FROM HOMELESS SHELTER, CHURCH OR OTHER SOCIAL HELP ORGANIZATION WHEN NO OTHER PROOF OF INCOME IS AVAILABLE.

I certify that no other source, including Medicaid, welfare programs, a parent, a legal guardian, a person, or an insurance company is legally responsible for my medical bills, I certify that my statements on this form are true and accurate to the best of my ability and I have stated accurately all facts pertaining to my finances.

Signature: _____ Date: _____

Patient Referred to: Dr. _____

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Internal Use Only: Approved: YES NO

If NO, state reason: _____

Signature: _____ Date: _____