Samaritan Daytop Village
Financial Hardship Application

The patient will need to complete a financial disclosure form (see attachment B) and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1) Documented proof that the patient is at or below 200% of the current federal poverty guidelines (see attachment B for 2025 guidelines). This can include documents such as

    a. W-2 withholding statements
    b. Paycheck stubs
    c. Income tax return
    d. Forms from Medicaid or other State-funded medical assistance
    e. Forms from employers or welfare agencies.

2) The patient has other circumstances that indicate financial hardship. These can be situations such as:

    a. proof of bankruptcy settlement
    b. catastrophic situations (death or disability in family, divorce)
    c. or other documentation that shows that the patient would be unable to pay the medical bill and still be able to pay for other basic necessary expenses.

Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases in income.

Any denial of a "financial hardship" discount request will be written and will include instructions for reconsideration. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered, per the above guidelines.

All information relating to financial hardship requests will be kept confidential.

OIG Special Fraud Alert (1994). OIG Advisory Opinion 97-4. Federal Register, Vol 65, No. 81, 4-26-00 pages 24401-2440742 CFR, section 1001.952 (k)HIPAA, section 231(h), section 1128A42 USC, Section 1320a-7aBBA, section 4331 False Claims Act, Public Law 104-191, Kennedy v Connecticut General Life Ins. Co (Case Law) 924 F.2d 698 (7th Cir. 1991) Managed Care Contracts

Attachment B

Financial Disclosure Form

Financial Hardship Discount Information Needed.

HHS Poverty Guidelines - Used to determine financial hardship based on income.

Household/ Family Size	2025 Federal Poverty Level for the 48 Contiguous States (Annual Income)						
	100%	133%	138%	150%	200%	300%	400%
1	$15,650	$20,815	$21,597	$23,475	$31,300	$46,950	$62,600
2	$21,150	$28,130	$29,187	$31,725	$42,300	$63,450	$84,600
3	$26,650	$35,445	$36,777	$39,975	$53,300	$79,950	$106,600
4	$32,150	$42,760	$44,367	$48,225	$64,300	$96,450	$128,600
5	$37,650	$50,075	$51,957	$56,475	$75,300	$112,950	$150,600
6	$43,150	$57,390	$59,547	$64,725	$86,300	$129,450	$172,600
7	$48,650	$64,705	$67,137	$72,975	$97,300	$145,950	$194,600
8	$54,150	$72,020	$74,727	$81,225	$108,300	$162,450	$216,600
Each person over 8, add	$5,500	$7,315	$7,590	$8,250	$11,000	$16,500	$22,000

Source: Federal Poverty Level (FPL) - HealthCare.gov Glossary | HealthCare.gov

Please provide the following information so we can complete your application:

- ☐ Most recent IRS tax forms (1040 and/or W-2) **(must be signed)**
- ☐ Check stubs for the past 30 days for all employed persons in the home.
- ☐ Unemployment check stubs for the past 30 days.
- ☐ Driver's license or identification card for adults.
- ☐ Proof of all other income received in the past 30 days.
- ☐ Proof of all outstanding bills (payment stubs, canceled checks, etc.)
- ☐ DSHS Denial letter.
- ☐ Medicaid forms or card
- ☐ Attached financial statement **(completely filled out and signed)**

Please sign the attached financial statement. Your request will NOT be processed if this form is not signed!

Please return all items (as applicable) on this checklist (in person or by mail).

Financial statement payment plan/uncompensated services application.

PATIENT NAME: _____

DATE(S) OF SERVICE:

NAME OF RESPONSIBLE PARTY:_____

RELATIONSHIP TO PATIENT:_____

SPOUSE: _____

TELEPHONE: _____

ADDRESS:_____

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD): _____

EMPLOYER:_____

ADDRESS:_____

IF UNEMPLOYED, FOR HOW LONG?_____

SPOUSE'S EMPLOYER: _____

ADDRESS:_____

IF UNEMPLOYED, FOR HOW LONG?_____

OTHER FAMILY MEMBER'S EMPLOYER(S):

(INCLUDE MEMBER NAME, EMPLOYER, & ADDRESS

_____

_____

_____

MONTHLY FAMILY INCOME & SOURCE

__Patient __Spouse __Responsible Party __Children Working

Monthly Salary (Gross) $_____

Public Assistance Benefits $_____

Unemployment Benefits $_____

Social Security Benefits $_____

Workman's Compensation $_____

Child Support $_____

Other (Alimony, Etc.) $_____

TOTAL FAMILY INCOME$_____

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE [YOUR COMPANY] TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

_____ _____
Signature of Person Making Request Date:

_____ _____
Signature of Spouse/Other Date:

DO NOT WRITE IN BOX – FOR OFFICE PERSONNEL USE ONLY

This document was received on _____(date)

by _____(Name/Title)

Approved by _____
(signature of provider/practitioner or office manager)