ERNEST
HEALTH, INC.

REQUEST FOR HARDSHIP ASSISTANCE

Attached is a Financial Disclosure Form that must be completed in order to determine if you will qualify for Hardship Exemption. The Financial Disclosure Form must be filled out completely and all verification of information attached before a determination can be made regarding final financial status.

The Financial Disclosure will then be reviewed and a determination made, it may help with all or a percentage of the charges incurred if approved.

ERNEST HEALTH will file all insurance, Medicare and Third Party Liability. If you qualify for any State Funded Programs please provide information regarding your application status. The Financial Disclosure and request for hardship is used as a last resource ONLY.

The Financial Disclosure Form will only be in effect for the dates of service that are currently being rendered. (Does not cover indefinitely).

However, based upon future discussions with you regarding your financial situation, the provider may determine that your financial situation has improved enough to remove the Hardship Exemption thereby requiring payment from you for the charges incurred.

THIS APPLICATION DOES NOT APPLY TO THE PHYSICIANS BILLING, YOU MUST CONTACT THE RESPECTIVE PHYSICIAN TO MAKE PAYMENT ARRANGEMENT FOR THEIR BILL.

By signing below and submitting the Financial Disclosure Form you agree to the best of your knowledge that the information contained therein is accurate.

_____ _____
Signature of Applicant Date

Approved: _____Yes _____ No

Approved or Non-Approved by:

_____ _____
(CFO and/or CEO) Date

Amount Approved: _____ Balance Due (If any):_____

Financial Disclosure Form

ERNEST HEALTH, INC.

_____ _____
Patient Name Address, City, State, Zip

_____ _____
Responsible Party Address, City, State, Zip

How long at this address?_____

Monthly Obligations:
Mortgage/Rent $_____ 1st Mortgage Holder_____ 2nd Mortgage Holder_____
Condo Fee $_____
Avg. Electric/Gas $_____
Avg. Telephone $_____
Avg. Water $_____
Insurance costs $_____
Car Payment $_____
Avg. Food Cost $_____
Credit cards (Itemize by Type:)

_____ _____
_____ _____
_____ _____
_____ _____

Child Support _____ Alimony _____
Other Medical/Dental _____ Other Expenses _____

Total Expenses: _____

Income:
Your employer: _____Monthly Income: _____ (Before Taxes)
Spouse's employer: _____Monthly Income: _____ (Before Taxes)
(Attach copies of past two months pay stubs)
Monthly child support/alimony Income: _____Other Income: _____

Total Monthly Income:_____

Savings Account Balance: _____ Credit Union: _____

Amount patient feels they can pay for services each month $_____

The above information is privileged and confidential.

_____ _____
Date Patient/Responsible Party Signature

Patient's estimated balance after insurance: _____ Account is approved for: _____

Comments: _____

Patient Account Manager: _____ Date: _____

Business Office Manager: _____ Date: _____

CFO/CEO _____ Date: _____

ERNEST HEALTH, INC.™

FINANCIAL ASSESSMENT

Date: _____

Patient Name_____ Date of Admission: _____

Account Number_____ Referred From_____

Admitting Diagnosis: _____

I **Potential Reimbursement**

[ ] Victim of Crime	**[ ] Accident/TPL**	**[ ] Charity Application**
[ ] Medicare	**[ ] Insurance**	**[ ] Self-Pay**
[ ] Medicaid	**[ ] Worker's Comp**	**[ ] Other: _____**

II **Demographic Information Update**

Address _____

City/State/Zip code _____

Telephone numbers: _____

D.O.B. _____/_____/_____ SSN: _____

III **Additional Contracts**

Name _____Relationship_____

Address _____

Telephone numbers _____

IV **Employment Information**

Name of Employer _____

Address _____

Telephone number _____Date of Employment _____

Date of Termination _____

Insurance coverage [ ] Yes [ ] No

If terminated, has coverage continued through COBRA? _____

V **Insurance Information**

List all insurance benefits whether primary secondary or if third party liability.

1. Name of Insurance _____
   Address _____
   _____
   Telephone number _____Contact _____

2. Subscriber Name _____
   SSN _____ Relationship _____

3. Policy Number/ Group Number _____
   Medicare/ Medicaid number _____

4. Effective Date _____

5. Pre-Cert Required _____ Pre-existing _____

VI **Victim of Crime**

1. Hospitalized due to violent crime (Not involved illegal activity)
   [ ] Yes [ ] No

2. Was Police Report taken? [ ] Yes [ ] No
   City _____ County _____

2. Date of Incident _____
   Location _____

VII **Third Party Liability/ MVA**

1. Date and Time of Accident _____
   Location _____
   City and County _____

2. Was the accident the fault of someone other than the patient/RP? _____
   a. Driver: _____
   b. Owner(s): _____
   c. Citation(s) Received: _____
   d. Driver's address/ telephone: _____
   _____
   e. Owner's Address/ Telephone: _____
   _____

3. Insurance coverage: _____
   Policy Number: _____

Insurance company's telephone number: _____

4. Has patient filed suit/planning to sue? [ ] Yes [ ] No

5. Name/ Address/ Telephone of Attorney: _____
_____
_____

6. Does the patient have Auto Insurance? [ ] Yes [ ] No
A. Name of Insurance company: _____
B. Policy Number: _____
C. Agent: _____
D. Address/ Telephone: _____

VIII **Workman's Compensation**
Hospitalization due to work related injury or illness

1. Patient still employed by same employer? [ ] Yes [ ] No

2. Name/ Address of Employer:_____
_____

3. Coverage verified? _____

4. Has a Worker's compensation claim been filed? [ ] Yes [ ] No
If Yes, Date Filed: _____

5. Attorney Name/ Address/ Telephone: _____
_____
_____

IX **Income Information/ Family Unit**
List every member of the family residing in household

Name	Rel	DOB	INCOME	SOURCE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

X **Potential Medicaid Category**
[ ] JUL/ Medicaid
[ ] Food Stamps

[ ] Medicaid only (Pregnant Women and Children)
[ ] Refugees
[ ] Institutional Care (Aged, Blind or Disabled)

[ ] SSI/ Disability
[ ] Potential Aged, Blind or Disabled
[ ] Deceased/ Presumptive SSI eligibility

XI **Complete this section if the patient has applied for medical assistance, or if the patient was previously eligible for medical assistance.**

HSD office location _____
Status of Application _____
Caseworker assigned_____
Date of Application _____Date of Denial _____
Reason for Denial _____
Dates of Eligibility _____

NARRATIVE: