HME Specialists LLC

Infusion Therapy Services
Specialty Mobility Services
Home Medical Equipment
Respiratory Services
Retail Store Front

Financial Hardship Application

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

Patient Name:				**Account Number:**	
Address:				**SSN:**	
City:		**State:**		**Zip Code:**	
Telephone Number:				**Date of Birth:**	
Name of person completing this application (if different from patient listed above):					
				Telephone Number:	
Relationship to patient:					
Number of people living in household (including yourself):					
Do you have health insurance? Medicare? Medicaid?	◯ Yes	◯ No			
If yes, what insurance do you have?					
If no, please explain why:					
☐ **Check here if you are unemployed.**				**How long?**	
Are you collecting unemployment benefits?	◯ Yes	◯ No			
☐ **Check here if you are on Social Security.**				**How long?**	
☐ **Check here if you are getting food stamps or other monetary assistance.**					
What type(s):					
☐ **Check here if you are on disability.**				**How long?**	
Did you file a Federal Income Tax Return last year?	◯ Yes	◯ No			
Will you file a Federal Income Tax Return this year?	◯ Yes	◯ No			
Please list all current employers:					
Employer 1:					
Employer 2:					
Employer 3:					

611 Osuna Rd NE ☼ Albuquerque, NM 87114 ☼ Phone: (505) 888-6500 ☼ Fax: (505) 888-6505

Financial Hardship Application (continued)

Please provide documentation of hardship. Appropriate documentation of a financial hardship would include:

1. Document proof that the patient is at or below 200% of the current federal poverty guidelines. Documents should include:
    a. Income tax return (signed copies of the last two years 1040 tax forms)
    b. Paycheck stubs for the past 90 days for all persons employed who reside in the household
    c. Current year Social Security of Disability letter with benefit amounts
    d. Unemployment check stubs for the past 90 days
    e. Proof of all other income received in the past 90 days
    f. Application forms from Medicaid or other State-funded medical assistance programs
2. Document proof that patient has other circumstances that indicate a financial hardship. These situations may include:
    a. Proof of all outstanding debts and/or bills (copies of billing statements, late notices, etc.)
    b. Proof of bankruptcy settlement (if applicable)
    c. Catastrophic situations (death or disability in the family, serious injury, divorce, etc.) or other documentation which demonstrates that the patient would be unable to pay for medical expenses yet still be able to pay for other basic expenses of daily living.
3. If applicable, describe patient indigent circumstances (please attach additional documentation if necessary):

Total monthly household income			
	Patient	Spouse/Parent	Dependents
Monthly Salary (gross)	$	$	$
Public Assistance Benefits	$	$	$
Unemployment Benefits	$	$	$
Disability Benefits	$	$	$
Social Security Benefits	$	$	$
Workers Compensation	$	$	$
Child Support	$	$	$
Food Stamps	$	$	$
Other	$	$	$
Subtotals	$	$	$
Total monthly household income		$	

I hereby acknowledge that the information given herein is true and correct. I authorize HME Specialists, LLC to verify information contained in this document for the sole purpose of assessing financial need.

Signature of person making request Date

Printed name of person making request

IMPORTANT: If all supporting documentation is not received, including **tax returns** and **proof of income** for every member of the household the application will be denied.