Allergy/Immunology Associates

Ohio Infusion Services

Financial Hardship Waiver

APPLICATION FOR MEDICARE CO-INSURANCE/CO-PAY WAIVER

Medicare law and most commercial insurance contracts, require a health care provider that accepts an assignment for services billed to the Medicare program or to the commercial insurance plan, 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 patient responsibility if the health care provider determines that the beneficiary does not have the ability to pay. To assist us in determining if you have the ability to pay, please answer the following questions:

First Name *(Required)*: **Last Name** *(Required)*:

Date of Birth *(Required)*: **Street Address** *(Required)*:

Street Address 2: **City** *(Required)*:

State *(Required)*: **Zip Code** *(Required)*:

Medicare/Insurance ID Number: **Email** *(Required)*:

Net Monthly Income from All Sources: **Family Size:**

1) Are you receiving any type of financial assistance from local, county, state, or federal government agencies? *(Required)*

- [ ] **Yes**
- [ ] **No**

If yes, describe this assistance:

2) Do you have other health insurance in addition to Medicare or the Private Insurance we have on file, that covers health related products or services? *(Required)*

- [ ] **Yes**
- [ ] **No**

If yes, give the name, address, and phone number of coverage:

3) Is a trust, guardian or anyone else legally responsible for your medical bills? *(Required)*

- [ ] **Yes**
- [ ] **No**

If yes, give the name, address, and phone number of this person:

MORE QUESTIONS ON THE FOLLOWING PAGE

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4) Do you own your own home? *(Required)*

- [ ] **Yes**
- [ ] **No**

5) How much do you have in savings to which you have immediate access? *(Required)*

POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES & THE DISTRICT OF COLUMBIA

[Source: HHS Poverty Guidelines, Federal Register, January 12, 2022.]

SIZE OF FAMILY UNIT	POVERTY GUIDELINE	200% OF POVERTY GUIDELINE
1	$13,590	$27,180
2	$18,310	$36,620
3	$23,030	$46,060
4	$27,750	$55,500
5	$32,470	$64,940
6	$37,190	$74,380

I certify that the above information is true and correct and I request that the 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 necessary documents to prove inability to pay.

- [ ] I have reviewed and agree to the Allergy/Immunology Associates Privacy Practices and Ohio Infusion Services Privacy Practices.

Signature _____ Date _____