Olney Counseling Center, LLC

office@OlneyCounseling.com

3300 Olney Sandy Spring Rd, Suite 340
Olney, MD 20832

(301)570-7500 Fax (301)570-7504

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 patient is at or below 200% of the current federal poverty guidelines (see attachment B for 2017 guidelines). This can include documents such as

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

2) 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 patient would be unable to pay 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 to income.

Any denial of "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.

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Financial Disclosure Form (attachment B)
Financial Hardship Discount Information Needed. HHS Poverty Guidelines-Used to determine financial hardship based on income.

FEDERAL POVERTY INCOME GUIDELINES
For Program Year 2017 to 2018
Maximum Income Levels

2017 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA				
Persons in Family/Household	100% FPL: Minimum to Qualify for ACA Assistance	138% FPL: Medicaid Cap (in States that Expanded)	250% FPL: CSR Subsidies Cap	400% FPL: Premium Tax Credit Cap
1	$12,060	$16,643	$30,150	$48,240
2	$16,240	$22,412	$40,600	$64,960
3	$20,420	$28,180	$51,050	$81,680
4	$24,600	$33,948	$61,500	$98,400
5	$28,780	$39,717	$71,950	$115,120
6	$32,960	$45,485	$82,400	$131,840
7	$37,140	$51,254	$92,850	$148,560
8	$41,320	$57,022	$103,300	$165,280
For families/households with more than 8 persons, add $4,180 for each additional person				

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Please provide following information so we may 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 persons employed in the home.
Unemployment check stubs for the past 30 days.
Drivers license or identification card for adults.
Proof of all other income received in the past 30 days.
Proof of all outstanding bills (payment stubs, cancelled checks, etc.)
Attached financial statement (completely filled out and signed)
Hardship Explanation
Expense support Documents
Any other documents to support application.

Please be sure to sign the attached financial statement.
Your request will NOT be processed if this is not signed.
Please return all items (as applicable) on this checklist (in person or by mail).

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Financial Hardship Statement Application.

PATIENT NAME: ____________________ DOB:____________________

NAME OF RESPONSIBLE PARTY:____________________SS#____________________

RELATIONSHIP TO PATIENT:____________________DOB:____________________

SPOUSE:____________________SS#____________________

TELEPHONE: ____________________ CELL:____________________

ADDRESS:____________________

EMAIL: ____________________

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD):________

EMPLOYER:____________________

ADDRESS:____________________

IF UNEMPLOYED, HOW LONG?:____________________

SPOUSE'S EMPLOYER:____________________

ADDRESS:____________________

IF UNEMPLOYED, HOW LONG?:____________________

OTHER FAMILY MEMBER'S EMPLOYER(S):____________________

(INCLUDE MEMBER NAME, EMPLOYER, & ADDRESS

____

____

____

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MONTHLY FAMILY INCOME & SOURCE

Patient

Monthly Salary (Gross)
$______________

Public Assistance Benefits
$______________

Unemployment Benefits
$______________

Social Security Benefits
$______________

Workman's Compensation
$______________

Child Support
$______________

Other (Alimony, Etc.)
$______________

Spouse

Monthly Salary (Gross)
$______________

Public Assistance Benefits
$______________

Unemployment Benefits
$______________

Social Security Benefits
$______________

Workman's Compensation
$______________

Child Support
$______________

Other (Alimony, Etc.)
$______________

Responsible Party

Monthly Salary (Gross)
$______________

Public Assistance Benefits
$______________

Unemployment Benefits
$______________

Social Security Benefits
$______________

Workman's Compensation
$______________

Child Support
$______________

Other (Alimony, Etc.)
$______________

Children Working

Monthly Salary (Gross)
$______________

Public Assistance Benefits
$______________

Unemployment Benefits
$______________

Social Security Benefits
$______________

Workman's Compensation
$______________

Child Support
$______________

Other (Alimony, Etc.)
$______________

TOTAL FAMILY INCOME$______________

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EXPENSES:

Mortgage/Rent (Attach copy of annual mortgage statement/rent agreement/receipts) $__________________

Alimony/Child Support Paid to: $______________________ (Please provide documentation of 3 months of payments)
Name:____

Address: ____

Telephone: ____

Groceries $______________________

Utilities (Attach documentation of 3 months of bills) $______________________

Medical (Attach copy of outstanding bills not paid by insurance) $______________________

Insurance (Attach copy of statement for auto, health, life, homeowners, etc.) $______________________

Auto Expenses (Include car payments, gas, maintenance receipts) $______________________

Installment Payments (Attach copy of statements) $______________________

Other Expenses (Explain) _____________________________ $______________________

(Attach documentation supporting other expenses)

TOTAL MONTHLY EXPENSES $______________________

Do you have health insurance? ___________

Do you have in/out benefits? ___________

Do you have a HAS/FSA account? ___________

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Do you have any circumstance in your life or family that would make paying the full fee for your treatment a hardship, i.e., unemployment, disability, excessive medical expenses, etc.? Please explain fully.

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE Olney Counseling & Psychiatric Center LLC 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: