Patient Name: _____ **Clinic Name: _____**

Clinicent ID: _____

TEXAS PHYSICAL THERAPY SPECIALISTS
REQUEST FOR FINANCIAL ASSISTANCE DUE TO HARDSHIP

You have been given this form because you indicated to an TexPTs staff member that you or your dependent minor are a current patient of Texas Physical Therapy Specialists (TexPTs) and due to the circumstances described below, are unable to pay the full amount of the applicable co-pay, coinsurance and/or any other non-covered services being provided by TexPTs. TexPTs is willing to provide financial assistance to you or your dependent minor in the form of a discount on your financial responsibility if circumstances exist evidencing a bona fide financial hardship. Any such assistance will be provided only upon (a) completion of this form, (b) submission of all documents required by this form, and (c) approval of your request.

Circumstances Causing Financial Hardship

In order to qualify for financial assistance, you must sufficiently demonstrate that your household income falls below a percentage of the Federal Poverty Guidelines. Please provide the documents listed below with your application for each adult household member. Please note that all information will be held confidential according to our privacy policy.

- A copy of last year's Federal Tax Return
- A copy of the two most recent payroll stubs or unemployment benefit payments

Income In Relationship to Federal Poverty Guidelines

Please provide the following information with respect to your family size and your family's household income.

The number of family members (myself, my spouse/partner & my children) who reside in my household is: _____
Spouse/Partner First Name: _____ Spouse/Partner Age: _____
Children/Dependent First Name(s): _____ Children/Dependent Age(s): _____

Annual Household Income (***Adjusted Gross Income***): $_____

I understand that this form and TexPTs' underlying policy does not constitute a contract or any right on my part to receive financial assistance from TexPTs. Any actual financial assistance provided by TexPTs will result only upon TexPTs obtaining all information required from me and TexPTs receiving all necessary internal corporate approvals. The actual type and amount of financial assistance provided by TexPTs, if any, will be determined at the sole discretion of TexPTs and communicated to me separately by TexPTs.

I understand that the law and the policy of TexPTs requires each patient covered by insurance to pay all deductibles, co-payments, and/or physical therapy costs. Accordingly, if I am not approved for financial assistance by TexPTs, then I will be responsible for payment of the amount of any co-pay, co-insurance, deductibles and/or any charges for non-covered services being provided to me or my dependent minor by TexPTs that are not reduced by this policy.

If I do qualify for assistance under this policy, I understand that such qualification is specific to me or my dependent minor for only the current course of treatment. If I or my dependent minor seek treatment beyond the current course of treatment, I must reapply for assistance under this policy and I must update all relevant information at that time.

ATTESTATION

I, _____, do hereby swear and affirm that the following are true and correct:

1. The statements I have made in the attached TexPTs Request for Financial Assistance Due to Hardship application and the requested documentation provided are true and correct.
2. I agree that I will immediately notify TexPTs if any of the statements in the application are no longer true and correct. If any of the statements I have made in the application and any of the documentation requested are not true and correct, then I agree that I will reimburse to TexPTs all amounts of financial assistance provided by TexPTs pursuant to the financial hardship policy described in the application.
3. I agree that in the event TexPTs requests that I provide any supporting information and/or documentation regarding my statements in the application, I will cooperate with TexPTs and immediately provide TexPTs with such information and documentation upon request.
4. With this Attestation and the application, I have provided a copy of my current driver's license, state ID, passport or other government document verifying my identity.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____	_____
Clinic Director Name	Clinic Director Signature	Date

Patient Name: _____ **Clinic Name: _____**

Clinicent ID: _____

TEXAS PHYSICAL THERAPY SPECIALISTS
REQUEST FOR FINANCIAL ASSISTANCE DUE TO HARDSHIP

INTERNAL APPROVAL OF ASSISTANCE

Checklist for internal approval of assistance (CC or CD please initial):

- ☐ Payment Plan Offered BEFORE Offering Hardship & Documented in EMR: Y____ or N_____
- ☐ Completed Assistance Application: _____
- ☐ Application Executed by Patient: _____
- ☐ Application Executed by Clinical Director: _____
- ☐ Attestation Executed by Patient: _____
- ☐ Verified Patient's Government ID (copy in EMR): _____
- ☐ Primary Insurance: _____
- ☐ Secondary Insurance: _____
- ☐ Current Balance Owed by Patient: _____
- ☐ Current Amount of Co-Pay: _____
- ☐ Current Co-Insurance Percentage: _____
- ☐ Deductible Obligation: _____
- ☐ Deductible Remaining: _____

Review and approval of the provision of assistance:

_____ _____
Financial Clearance Manager Signature Date

Assistance Approved:

- ☐ Co-Pay Discount
  Current Amount of Co-Pay: _____
  Amount of Discount: _____
  New Co-Pay Amount: _____

- ☐ Co-Insurance Discount
  Current Co-Insurance Percentage: _____
  Amount of Discount: _____
  New Co-Insurance Percentage: _____

AGREEMENT TO PAY BASED ON REQUEST FOR FINANCIAL HARDSHIP

Based on the circumstances identified in the REQUEST FOR FINANCIAL ASSISTANCE DUE TO HARDSHIP application, you as the patient or legal guardian of the patient, agree to the below terms and amount for the current physical therapy care:

☐ Co-Pay Discount
Current Amount of Co-Pay: _____
Amount of Discount: _____
New Co-Pay Amount: _____

☐ Co-Insurance Discount
Current Co-Insurance Percentage: _____
Amount of Discount: _____
New Co-Insurance Percentage: _____

This agreement is confidential. Any disclosure of this agreement may result in termination of this agreement.

Patient Name: _____
(Please Print)

Signature: _____
(Patient or Guardian of Patient)