

**Partners In Internal Medicine**  
**Financial Hardship Request Form**

(All requests are kept completely confidential and the information provided will only be used to determine eligibility)

Patient Name: \_\_\_\_\_ Account#: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Insurance Coverage Information:**

Primary Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_

Medicare                       Medicaid                       Veterans' Benefits

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**Please answer the following questions**

Employment Status:  Employed -Salary: \$ \_\_\_\_\_ Wkly/Month \_\_\_\_\_

Unemployed:  Retired / Income: \$ \_\_\_\_\_  Disability/\$ \_\_\_\_\_

# of dependents living in household: \_\_\_\_\_

Housing Status:     \_\_\_ Rent     \_\_\_ Own     Monthly Payment:\$ \_\_\_\_\_

Please provide an explanation why you are unable to pay your medical bill(s), including information about any change in economic status.

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**Please submit two of the following documents**

- Copies of pay-stubs (2-months)     Employment verification letter including Y-T-D earnings & pay rate
- Copy of Social Security Income, Social Security Disability, General Assistance or Aid to Dependent Children benefit letter.
- Copy of Federal & State Tax Returns or W-2 statement for past 2 years.     Copy-3 mths bank statements
- If requested to apply, a copy of your Medicaid denial.

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I certify that no other source, including Medicaid, welfare program, a parent, a legal guardian, or person or insurance program is legally responsible for my bills. I certify that my statements on this form are true and accurate to the best of my ability and that I stated all facts involving my finances.

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Signature

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Date

**Partners In Internal Medicine  
Financial Hardship Approval/Denial Form**

Upon individual review of economic hardship, Partners In Internal Medicine agrees to waive the collection of medical expenses not reimbursed by medical insurance on the above patient/family. This waiver automatically expires after a period of \_\_\_\_\_ months unless renewed by PIIM, Operations Manager. This waiver may be immediately revoked by undersigned, without advance notice, for any reason.

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Date

Upon individual review of economic hardship, Partners In Internal Medicine does not agree to waive the collection of medical expenses that are not reimbursed by medical insurance on the above patient/family. Partners In Internal Medicine expects payment in full of all amounts owed. Partners In Internal Medicine will make every effort to work reasonable payment arrangements with the applicant (patient).

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Date