



APPLICATION FOR FINANCIAL HARDSHIP ASSISTANCE

Tribal Diagnostics abides by the contractual and legal obligations of health benefit plans to collect charges, co-pays, co-insurance, and deductible amounts owed by patients. We also recognize that circumstances may arise where an individual is unable to pay the full amount of the patient cost-sharing obligation at the time of dispensation. We have adopted a policy of screening requests for discounts, payment plans, or forgiveness of debt based on individual circumstances. To do this, we must ask for certain financial information. All information provided will be held in confidence. Please provide the documents listed below for each adult family member, and complete this form to the best of your ability.

Patient Name: _____ DOB: _____

Estimated Patient Responsibility: \$ _____ Date of Dispensation: _____

Number of People in Household: _____

Household Income: \$ _____

Provide Tribal Diagnostics the following documentation:

1. Copy of previous year's tax return; or
2. Copies of the last payroll check stub (or unemployment, disability payment stubs, etc.);
and
3. Copies of the last month's bank statement

Are there any extenuating financial circumstances (*e.g.*, unemployment, debt, etc.) that Tribal should consider in reviewing this Application?

[CONTINUE FORM ON NEXT PAGE]

HOUSEHOLD FINANCIAL INFORMATION

Monthly Income (after payroll deductions)		Monthly Expenses (not including payroll deductions)	
Employment	\$	Mortgage/Rent	\$
Unemployment/ Severance	\$	Auto/Transportation	\$
Self-Employment	\$	Non-reimbursed work expenses (e.g., parking, tools)	\$
Interest/Dividends	\$	Insurance (e.g., life, homeowners)	\$
Pension/Disability	\$	Utilities (e.g., water, light, gas)	\$
Child Support/Alimony	\$	Medications	\$
Short-Term Disability	\$	Childcare	\$
Long-term Disability	\$	Credit Cards	\$
Rental Income	\$	Child Support/Alimony	\$
Other Income	\$	Personal Property Taxes (e.g., home, auto)	\$
		Other Expenses	\$
Total Average Income	\$	Total Average Expenses	\$



Under the Penalty of Perjury, I attest that the information set forth above is true and accurate to the best of my knowledge.

Patient's/Guarantor's Signature

Date

Return this form to: Tribal Diagnostics
 Attention: Billing Department
 9217 S. Eastern Avenue
 Oklahoma City, OK 73160