

**Policy:**

Sonoran Orthopaedic Trauma Surgeons, P.L.L.C. has established this policy in an order to maintain consistency in assisting uninsured, indigent and those patients with substantial financial issues who request a reduction or waiver of certain medical charges.

Co-payments, deductibles, or other owed amounts that are the patient's responsibility under the rules of the Medicare, Medicaid or any other governmental or commercial third-party payer may not be waived, except on a case by case basis upon a determination of financial need. Routine waiver of co-payment, deductible, or other owed amounts may be a violation of federal law and is a violation of Sonoran Orthopaedic Trauma Surgeons policy.

**Documentation:**

You will be required to provide documentation to Sonoran Orthopaedic Trauma Surgeons in order to assist us in determining a decision regarding reduction or waive of charges owed for services provided by Sonoran Orthopaedic Trauma Surgeons.

- W-2 withholding statements or Unemployment check stubs for the past 90 days.
  - Pay check stubs for the past 90 days for all persons employed in the home.
  - Proof of all other income received in the past 90 days.
  - Proof of all outstanding debts or bills (copies of bills, statements, late notices).
  - Proof of Bankruptcy settlement (if applicable).
  - Other (Please describe other circumstances):
- 
- 

***If approved, Sonoran Orthopaedic Trauma Surgeons may elect to reduce or waive certain amounts which are due from the Patient and/or guardian/guarantor who can successfully demonstrate that paying these medical charges would cause significant financial hardship.***

## Financial Hardship Application

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

1.) Are you receiving any type of assistance from local, county, state or federal government agencies? If yes, what types of assistance are you qualified to receive?

\_\_\_\_\_

2.) If not, do you qualify for assistance from local, county, state or federal government agencies? If so, what types of assistance are you qualified to receive?

\_\_\_\_\_

3.) Do you have other health insurance that covers health related products or services?

Yes  No \* If "Yes", list the companies and policy numbers:

\_\_\_\_\_

\_\_\_\_\_

4.) Is a guardian or anyone else legally responsible for your medical bills?

Yes  No \* If "Yes", give name, address and phone numbers of this person:

\_\_\_\_\_

\_\_\_\_\_

5.) Are you employed?

Yes  No \* If "Yes", please provide employer's name, address and phone number:

\_\_\_\_\_

\_\_\_\_\_

What is your pay period?  Weekly  Bi-weekly  1<sup>st</sup> & 15<sup>th</sup>  Other: \_\_\_\_\_

What is your Gross per pay period? \_\_\_\_\_

What is your Net per pay period? \_\_\_\_\_

6.) Do you own your home?  Yes  No

Are you still making payments on it?  Yes  No Monthly payments are: \_\_\_\_\_

7.) How much do you have in Savings to which you have immediate access? \_\_\_\_\_

8.) What are your Monthly Net income from?

Your Employment: \_\_\_\_\_

Social Security: \_\_\_\_\_

Retirement \_\_\_\_\_

Investments: \_\_\_\_\_

Other: \_\_\_\_\_

Total Monthly Income: \_\_\_\_\_

9.) What are your Monthly Expenses:

Rent/House payment: \_\_\_\_\_

Utilities: \_\_\_\_\_

Car payment: \_\_\_\_\_

Other Transportation: \_\_\_\_\_

Food: \_\_\_\_\_

Medical bills: \_\_\_\_\_

Other: \_\_\_\_\_

Total Monthly Expenses: \_\_\_\_\_

I certify that the above information is true and correct. I request that you consider me for reduction or waiver of charges/balance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of representative if patient is unable to sign

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Reason patient is unable to sign

---

---

## FOR OFFICE USE ONLY

### Reduction of Charges/Balance

Approved    Denied

% of Reduction: \_\_\_\_\_

Reduction in effect for date(s) ONLY:  
\_\_\_\_\_

### Waiver of Charges/Balance

Approved    Denied

Amount Waived \$ \_\_\_\_\_

Waiver in effect for date(s) ONLY:  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title