PATIENT APPLICATON FOR FINANCIAL HARDSHIP

Instructions to Patient:

Please complete this form in its entirety and return to:

Milwaukee Fire Department
1105 Schrock Road, Ste 610
Columbus, Ohio 43229

Account#:_____

Patient Name: _____

Address: _____

City/State/Zip: _____

Responsible Party (if different than patient): _____

City/State/Zip of Responsible Party: _____

I am applying for a Hardship Determination in order that you will consider waiving my co-pay/co-insurance/deductible (or total charge if uninsured) for services and care provided to me on _____ (date of service).

I am supplying the following information so that you can make an accurate determination of my case. The monthly dollar amount provided is from all sources, including Social Security Benefits, pensions, annuities, dividends, etc. Attached you will find verification of my employment/unemployment status and copies of my federal tax returns or W-2 forms for the current and previous years.

(CONTINUE ON NEXT PAGE)

Monthly Income:	**Self:**		**Spouse:**		
Wage/Salary	$_____		$_____		
Social Security	$_____		$_____		
Pension	$_____		$_____		
Interest Income	$_____		$_____		
Other	$_____		$_____		
Total:	$_____	+	$_____	=	$_____

Size of Household (please include yourself): _____

Statement of Agreement: "I am supplying this information to request that the *Milwaukee Fire Department* waive collection of all or part of the Medicare or other deductible/co-insurance amounts, in my case, due to financial hardship. I also understand that the *Milwaukee Fire Department* can and will begin to attempt to collect charges should my financial situation improve. I agree to be responsible for any balance remaining after the application of any waiver by *the Milwaukee Fire Department*, if any."