Hematologics, Inc.
Billing Office: PO Box 24712, Seattle, Washington 98124
Billing Office Phone: (206)799-9491, Billing Office Fax: (866) 383-6743
Billing Office Email: billing@hematologics.com

2027 FINANCIAL HARDSHIP APPLICATION
FOR WAIVER OF COPAY/DEDUCTIBLE

The patient will need to complete a financial disclosure form (see attachment B) and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1) Documented proof of patient's income in relation to the current federal poverty guidelines, see chart on page 3. This can include documents such as:

   a. W-2 withholding statements
   b. Pay-check stubs
   c. Income tax return
   d. Forms from Medicaid or other State-funded medical assistance
   e. Forms from employers or welfare agencies.

2) Patient has other circumstances that indicate financial hardship. These can be situations such as:

   a. proof of bankruptcy settlement
   b. catastrophic situations (death or disability in family, divorce)
   c. documentation that shows that patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses.

Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

Any denial of "financial hardship" discount request will be written and will include instructions for reconsideration. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered per the above guidelines.

Completion of this application does not mean your request will be granted or that you will be relieved of financial responsibility.

All information relating to financial hardship requests will be kept confidential.

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Financial Assistance Guidelines. Eligibility criteria for Financial Assistance may include, but is not limited to, such factors as Family size, liquid and non-liquid assets, employment status, financial obligations, amount and frequency of healthcare expense (i.e. Medically Indigent) and other financial resources available to the patient. In particular, eligibility for Financial Assistance will be determined in accordance with the following guidelines:

Uninsured Patients:

1) If Family income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for a 100% discount against Charges for Laboratory Services;
2) If Family income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 50% discount against Charges for Laboratory Services;
3) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

Underinsured Patients:

1) Payment plans will be extended for any patient liability (including without limitation to amounts due under high-deductible plans) identified in a manner consistent with the System's Payment Plan Policy;
2) If Family Income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 100% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the uninsured/non-covered rate for each laboratory test;
3) If Family Income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to 50% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the uninsured/non-covered rate for each laboratory test;
4) Family size is determined based upon the number of dependents living in the household;
5) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

Medically Indigent:

Patients will be required to submit a Financial Assistance application along with other supporting documentation, such as medical bills, drug and medical device bills and other evidence relating to high-dollar medical liabilities, so that the appropriate Hematologics billing manager can determine whether the patient qualifies for Financial Assistance due to the patient's medical expenses and liabilities.

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FINANCIAL DISCLOSURE FORM

Federal Poverty Guidelines are used to determine financial hardship based on annual income.

2027 Federal Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	$15,960	$19,950	$18,360
2	$21,640	$27,050	$24,890
3	$27,320	$34,150	$31,420
4	$33,000	$41,250	$37,950
5	$38,680	$48,350	$44,480
6	$44,360	$55,450	$51,010
7	$50,040	$62,550	$57,540
8	$55,720	$69,650	$64,070
For each additional person, add	$5,680	$7,100	$6,530

Please provide following information as appropriate so we may complete your application:

- ☐ Most recent IRS tax forms (1040 and/or W-2) (Must be signed)
- ☐ Check stubs for the past 30 days for all persons employed in the home
- ☐ Unemployment check stubs for the past 30 days
- ☐ Proof of all other income received in the past 30 days
- ☐ Proof of all outstanding bills (payment stubs, cancelled checks, etc.)
- ☐ Medicaid Denial letter
- ☐ Attached financial statement (completed and signed)

Please be sure to sign the attached financial statement. Your request will NOT be processed if this is not signed. Please return all items (as applicable) on this checklist (by fax, email or paper mail).

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Financial Statement and Financial Aid Application.

PATIENT NAME: _____

DATE(S) OF SERVICE: _____

NAME OF RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT: _____

SPOUSE: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

NUMBER OF FAMILY MEMBERS LIVING IN HOUSEHOLD: _____

EMPLOYER: _____

ADDRESS: _____

IF UNEMPLOYED, HOW LONG?: _____

SPOUSE'S EMPLOYER: _____

ADDRESS: _____

IF UNEMPLOYED, HOW LONG?: _____

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MONTHLY FAMILY INCOME AND SOURCE

_____ Patient _____ Spouse _____ Parent or other Responsible Party

Monthly Salary (Gross) $_____

Public Assistance Benefits $ _____

Unemployment Benefits $ _____

Social Security Benefits $ _____

Workman's Compensation $ _____

Child Support $ _____

Other (Alimony, Etc.) $ _____

TOTAL FAMILY INCOME $_____

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE (YOUR COMPANY] TO VERIFY ANY INFORMATION
CONTAINED IN OR ATTACHED TO THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

_____ _____
Signature of Person Making Request Date

_____ _____
Signature of Spouse/Other Date

DO NOT WRITE BELOW THIS LINE – FOR OFFICE PERSONNEL USE ONLY

This document was received on _____
Date

By _____
Name and Title

Approved by _____
Signature of billing manager or laboratory director