EQUALTOX
LABORATORY

PATIENT FINANCIAL HARDSHIP APPLICATION
PLEASE MAIL BACK TO BILLING OFFICE AT:
1562 Parkway Loop, Suite B
Tustin, Ca 92780

_____
Patients Name & Balance

Equaltox abides by the contractual and legal obligations of health benefit plans to collect all charges, co-pay, co-insurance, and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full, Equaltox has adopted a policy of screening requests for discounts, delayed payment plans, or forgiveness of debt based on individual circumstances. In order to do this, we must ask for certain financial information. Please complete the following form to the best of your ability and provide the following supporting documentation: APPLICATION WILL NOT BE REVIEWED IF WE DO NOT RECEIVE ALL ITEMS REQUESTED AND/OR IF ANY INFORMATION IS OMITTED.

- A copy of last year's tax return; (MUST BE SIGNED)
- Information from two recent payroll or unemployment benefit payments; for all persons employed in the home
- If income is close to or below poverty level, denial of state medical assistance
- Forms from employers or welfare agencies

All information will be held confidential as per Practice Name privacy policy.

Patient Name: _____ DOB: _____ SS#: _____
Spouse Name: _____ DOB: _____ SS#: _____
Guarantor name(s): _____ Dates of services: _____
Number of dependents per guarantor household: _____ Number in school: ____ Household total: ____
Phone: _____ E-mail: _____
Attached copy of Driver's License or identification card for all adults.

Type of Assistance Requested:
Reduced deductible _____ Reduced co-pay/co-insurance/Non covered _____ Discounted cash services _____ Payment plan _____

Employment/Unemployment Information (for each adult family member):
Employer name: _____
Address: _____
Phone: _____
If unemployed please state when employment terminated or if lay-off is temporary, indicate expected duration:
_____
_____ Assistance
Received:
State financial assistance _____WIC _____ Food Stamps _____ Charity Care/other _____
_____ Property/Investment
Values:
Home _____ Other real estate owned _____ Land _____
Business _____ Livestock _____
Savings/stocks/bonds _____ Other Investments_____

Please complete the information in the following table based on average income and expenses over the last twelve months. For amounts paid annually, enter annual amount divided by twelve. 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		Insurances (e.g., life, homeowners)	
Pension/disability		Utilities (lights, water, gas, trash)	
Child support/alimony		Medications	
Short-term disability		Childcare	
Long-term disability		Credit cards	
Rental income		Child support/alimony	
Other income:		Personal property taxes (home, auto)	
		Other:	
Total average income		**Total average expenses**	

By my signature below, I certify that this information is true and complete. I grant **Equaltox** permission to verify this
information and acknowledge that completion of this form does not guarantee discount, payment plan, or forgiveness of debt.
Signed: _____ Date: _____

The 2016 Poverty Guidelines for the
48 Contiguous States and the District of Columbia
Persons in family Poverty guideline

Persons in family	Poverty guideline
1	$11,770
2	$15,930
3	$20,090
4	$24,250
5	$28,410
6	$32,570
7	$36,730
8	$40,890
For families with more than 8 persons, add $4,160 for each additional person	

PLEASE DO NOT WRITE BELOW. FOR OFFICE USE ONLY

Received hardship letter from patient on: _____ (Letter attached)
Application Reviewed by: _____ Date: _____
Approved for: Discounted amount $ _____ Forgiveness of debt $_____ Payment Plan. First Payment due on: _____
Monthly Payment $_____ Approved On: Date: _____ By: _____
Next review date: _____