Athelas
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PATIENT FINANCIAL HARDSHIP APPLICATION

Athelas, LLC ("Athelas") complies with all contractual and legal obligations to collect charges, co-payments, co-insurance, and deductible amounts owed by patients. Cost-sharing obligations are not routinely waived and are collected in accordance with applicable contractual and legal requirements. Athelas recognizes that circumstances may arise where an individual is unable to pay cost-sharing obligations in full at the time of service. In such cases, Athelas may consider requests for discounts, payment plans, or partial forgiveness of cost-sharing obligations based solely on documented individual financial need and in accordance with the Athelas Policy and Procedure for Patient Assistance (GRP-002) and applicable law. Financial assistance determinations are made solely on the basis of documented financial need and are not related in any way to the volume or value of referrals or other business generated for Athelas or its customers. Submission of this application does not guarantee approval. Approved assistance may be time-limited and subject to periodic review. All information provided will be treated as confidential in accordance with Athelas' Privacy Policy.

Required Documentation (for each adult household member)

Please provide copies of the following:

- Most recent federal tax return (if available)
- Two most recent payroll stubs or proof of income
- Proof of unemployment benefits (if applicable)
- Documentation of state medical assistance application and denial (if income is near or below applicable poverty guidelines)

Additional documentation may be requested if necessary to verify financial need.

Patient Information

Patient Name: _____

Date of Birth: _____

Responsible Party (if different): _____

Address: _____

City/State/Zip: _____

Phone: _____

Email: _____

Number of Dependents in Household: _____

Number Currently Enrolled in School: _____

Type of Assistance Requested

☐ Reduced co-payment / co-insurance

☐ Reduced deductible

☐ Discounted self-pay services

☐ Payment plan

☐ Partial balance forgiveness

Employment Information (Each Adult Household Member)

Name: _____ Employer: _____

Employer Address: _____

Employer Phone: _____

Name: _____ Employer: _____

Employer Address: _____

Employer Phone: _____

If unemployed, please state date employment ended and expected duration of unemployment:

_____

_____

Government or Public Assistance Received

☐ Medicaid

☐ State Medical Assistance

☐ SNAP / Food Assistance

☐ WIC

☐ Disability Benefits

☐ Other: _____

Property / Asset Information

Primary Residence (Estimated Value): $_____

Other Real Estate: $_____

Savings / Checking Accounts: $_____

Stocks / Bonds / Investments: $_____

Business Interests: $_____

Other Assets: $_____

Additional Notes:

_____
_____
_____

Household Financial Information

(Provide average monthly amounts. For annual payments, divide by 12.)

Monthly Income (After Payroll Deductions)

Employment Income: $_____

Self-Employment Income: $_____

Unemployment / Severance: $_____

Disability / Pension: $_____

Child Support / Alimony Received: $_____

Rental Income: $_____

Other Income: $_____

Total Monthly Income: $_____

Monthly Expenses

Mortgage / Rent: $_____

Utilities: $_____

Transportation / Auto: $_____

Insurance: $_____

Medical Expenses (Non-reimbursed): $_____

Childcare: $_____

Credit Card / Loan Payments: $_____

Child Support / Alimony Paid: $_____

Other Expenses: $_____

Total Monthly Expenses: $_____

Certification and Authorization

I certify that the information provided in this application is true, complete, and accurate to the best of my knowledge. I understand that submission of this Application does not entitle me to any discount, waiver, or payment arrangement, and that any determination is made solely at the discretion of Athelas in accordance with its Policy and Procedure for Patient Assistance (GRP-002) and applicable law.

I authorize Athelas to verify any information provided, including contacting employers or reviewing documentation submitted, and to retain this Application and all supporting documentation for compliance, audit, and recordkeeping purposes.

I understand that any material misrepresentation or omission may result in denial or reversal of assistance.

Signature: _____

Printed Name: _____

Date: _____

Internal Review (For Athelas Use Only)

Reviewed By: _____

Title: _____

Date Reviewed: _____

Decision:

☐ Approved – Discount %: _____%

☐ Approved – Payment Plan

☐ Approved – Partial Forgiveness

☐ Denied

Notes:

_____
_____
_____
_____

Next Review Date (if applicable): _____