PERSONAL SUPPORT MEDICAL SUPPLIERS

Financial Waiver Request

Patient First Name MI Last Name

Patient ID#

DOB M M D D Y Y Y Y

Patient's Address: ____

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SECTION 1: NOTIFICATION REQUEST WAIVER

I represent to Personal Support Medical Suppliers that my financial resources and income are limited. I request a waiver of my co-insurance and/or deductible responsibility for equipment, supplies and services provided so that I shall not be required to pay the percentage normally payable by the beneficiary.

I understand that this form represents a request of waiver of my co-pay and/or deductible charges. I must provide information as outlined on the attached worksheet so the extent of my ability to pay for these expenses can be evaluated. I also understand that the final decision regarding the extent of my financial responsibility will be communicated to me after this information has been reviewed.

I certify that the financial information I am submitting is correct and true. I also certify that there is no other insurance coverage, government assistance, or agencies that would cover the amount owed by me. Further, I certify that I do not have any immediate family member(s) or any other relative who could help me with this balance. I give my permission to Personal Support Medical Suppliers to investigate the accuracy of the financial information provided. I understand this information is to be used solely for the purpose of evaluating my ability to pay for the services provided. I also understand that this information any be shared with my insurance company. If my financial condition changes, I will promptly notify PERSONAL SUPPORT MEDICAL SUPPLIERS.

______________________________________ ___________________________ ______/______/________

Patient or Authorized Representative Signature Relationship to Patient Date

SECTION 2: CUSTOMER FINANCIAL DISCLOSURE

COMPLETE PAGE 2 FINANCIAL DISCLOSURE WORKSHEET (ATTACHED)

WAIVER DECISION (PSMS internal use only)

☐ Waiver Approved ☐ Full Waiver

☐ Waiver Denied ☐ Partial Waiver/Monthly plan $ _________________

____ Date Signed _____/_____/_______

Manager (signature)

____

Manager (print name)

____ Date Signed _____/_____/_______

Other Appointed Manager (signature)

____

Other Appointed Manager (print name)

____

Other Appointed Manager Title

REVISED 11/10/2010

PERSONAL SUPPORT MEDICAL SUPPLIERS

Financial Disclosure Worksheet

Patient Name ____ Date _______________________

Patient ID# ____

ASSETS	SELF	SPOUSE	TOTAL
Cash on Hand (Checking, Savings, CDs, Money Market)	$ ____________	$ ____________	$ ____________
Stocks, Bonds, Credit Union Savings	$ ____________	$ ____________	$ ____________
Real Estate Owned (excluding primary residence)	$ ____________	$ ____________	$ ____________
Automobile(s)	$ ____________	$ ____________	$ ____________
Life Insurance Cash Value	$ ____________	$ ____________	$ ____________
Other Property	$ ____________	$ ____________	$ ____________
TOTAL ASSETS:	**$** ____________	**$** ____________	**$** ____________
Credit Cards (other debts owed)	$ ____________	$ ____________	$ ____________
Mortgages (Excluding Primary Residence)	$ ____________	$ ____________	$ ____________
Auto Loan	$ ____________	$ ____________	$ ____________
Other Debts- list (Student loans, other loans,	$ ____________	$ ____________	$ ____________
etc.)	$ ____________	$ ____________	$ ____________
	$ ____________	$ ____________	$ ____________
	$ ____________	$ ____________	$ ____________
Total Liabilities	**$** ____________	**$** ____________	**$** ____________
Net Worth (Assets Less Liabilities)	**$** ____________	**$** ____________	**$** ____________
Monthly Income	$ ____________	$ ____________	$ ____________
Income: Salary, Social Security, Workers Compensation, Veteran's Benefits Alimony, Child Support	$ ____________	$ ____________	$ ____________
Interest and Dividends	$ ____________	$ ____________	$ ____________
Gross Rent from Owned Property	$ ____________	$ ____________	$ ____________
Other Income (list)	$ ____________	$ ____________	$ ____________
	$ ____________	$ ____________	$ ____________
Total Income per Month	**$** ____________	**$** ____________	**$** ____________
Monthly Expenses	$ ____________	$ ____________	$ ____________
Mortgage/Rent	$ ____________	$ ____________	$ ____________
Automobile Loans	$ ____________	$ ____________	$ ____________
Monthly expenses for utilities, telephones, food, clothing, medical insurance, prescriptions, etc	$ ____________	$ ____________	$ ____________
Other	$ ____________	$ ____________	$ ____________
	$ ____________	$ ____________	$ ____________
	$ ____________	$ ____________	$ ____________
Total Monthly Expenses	**$** ____________	**$** ____________	**$** ____________
Available Cash per Month (income less expenses)	$ ____________	$ ____________	$ ____________

Number of people in household ________

_______________________________________ _______________________ _____________

Patient or Authorized Representative Signature Relationship to Patient Date