Apria Healthcare
Patient Financial Services Department
1328 S. Highland Avenue
Jackson, TN 38301
TEL: 866-713-1870 FAX: 949-614-7691

Dear Valued Patient,

Enclosed for your review and completion is the application for a financial hardship waiver. Financial hardship waivers are effective for six months, and are limited to patients who meet all of the following criteria:

- A primary insurer for health coverage; and
- Total payments due for rental equipment exceed $100 per month; and
- Gross household income less than 400% of the Federal Poverty Guidelines

Deductibles, out-of-network balances, sale items, and other patient costs unrelated to the monthly rental of equipment are excluded for determining eligibility but waived if hardship is approved.
You must return the completed and signed application, along with supporting documentation. If your application is for a renewal of an existing waiver, you must return all documentation by _____/_____/________.

You remain responsible for payment on any open patient balances until your application is reviewed and approved by the Patient Financial Services (PFS) Department. Apria Healthcare will notify you in writing of your application status, via a PFS Notification letter, within 30 days of receiving the application. If approved, you must sign and return the PFS Notification letter to Apria Healthcare within 14 days for your hardship waiver to become effective.

Application information will be kept confidential and used only in connection with reviewing your application for a financial hardship waiver. If there are significant changes in your financial circumstances, such as a change in your insurance which pushes your co-pay below the criteria, you are expected to promptly notify Apria Healthcare.

The financial assistance for which you may qualify depends on factors such as income and the number of persons in your household. So Apria can verify the household income, the patient (or the patient's caregiver/guarantor) is required to attach a copy of all applicable documents from the following list for all household members to his or her application:

- Income tax return for the previous year
- W-2 statement for the previous year
- Pay stubs covering the most recent three months
- Proof of Social Security / Disability Income —1099 form, annual award letter, or bank statement showing the amount of direct deposit
- Unemployment compensation form, documented worker's compensation
- Documentation of alimony, child support, AFDC, food stamps
- Written statement from one or more public welfare agencies verifying income for the previous 12 months

Apria Healthcare wants to provide you with the highest level of customer service. If you have questions regarding the application, you can reach an Apria Healthcare billing expert at 866-713-1870, Monday through Friday, between 8:00 AM and 6:00 PM Central Time.

If approved, your financial hardship waiver is effective for six months. If you continue to meet all criteria above and want to apply for an additional six months of financial hardship waiver, you will be required to submit a new application.

Financial Hardship Waiver Application

Confidential

APPLICATION INFORMATION

Please fill all fields completely and accurately

Section	Field		Field	
General Information	Patient name:	________________	Patient SSN:	________________
	Date of birth:	________________	Account ID#:	________________
	Home phone:	________________	Number in household:	________________
	Work phone:	________________	Email / FAX#:	________________
	Address:	________________	City, State, ZIP:	________________
	Responsible party:	________________	Responsible party SSN:	________________
Total Household Income Fill in all that apply to your household	Gross wages / tips:	________________	Rental income earned:	________________
	Alimony:	________________	Interest / dividends:	________________
	Child support:	________________	Bonuses / Commissions:	________________
	Social Security:	________________	SSI / Disability	________________
	Pension:	________________	Food stamps:	________________
	Retirement:	________________	Other:	________________
	Unemployment:	________________	**Total Monthly Income:**	$________________
Insurance Information If applicable	Company:	________________	ID / Policy number:	________________
	Phone:	________________	Group number:	________________
	Address:	________________	Effective date:	________________
		________________		

Your insurance company or government payor (e.g., Medicare) and applicable laws and regulations require all providers, including Apria, to make reasonable efforts to collect all out-of-pocket co-payments, deductibles, co-insurance, and related beneficiary cost-share amounts (“patient responsibility”). By law, we must attempt to collect the patient responsibility unless we determine, in good faith, that your payment of your patient responsibility would cause genuine financial hardship.

By signing below, I acknowledge and agree that, to the best of my knowledge, the financial information provided above is an accurate statement of my financial status, and I further acknowledge that Apria Healthcare will rely on the information I provide to make a financial hardship determination. I understand this request must be reviewed by Apria Healthcare before a waiver of financial responsibility can be made. I authorize Apria Healthcare and/or any person or entity acting on its behalf to obtain credit reports to verify the information provided in or pursuant to the above application and/or to verify my eligibility for a hardship waiver. I further understand that if approved, I will be required to complete a new financial hardship application to qualify for additional hardship waivers, which may be in different amounts than approved for previous hardship waivers. I further understand that waiver of my financial obligation to Apria Healthcare does not cover amounts deemed patient responsibility due to non-compliance with insurance and/or physician requirements, willful breakage, or theft of equipment.

Patient signature: ______________________________ Date: ______________

Responsible party signature: ______________________________ Date: ______________ (If other than the patient)