FINANCIAL HARDSHIP ASSISTANCE APPLICATION
Please mail to: PO Box 476, Elkin, NC 28621
or fax to: 800-975-6321

Patient Name (print)____ Acct # ___________________________

Street _________________________________ Apt ________ City ______________________ State ____Zip ______

Billing Address, if different ____

Email ___________________________________ Phone ______-______-________ Alt Phone ______-_____-________

Prism Medical Products, LLC understands you may have difficulty paying your remaining balance. Therefore, we are pleased to offer a Hardship Program to help meet your needs. Please take time to fully complete the application form and promptly submit to our office for review. It is important to us that you have access to the equipment you need.

HOUSEHOLD

Household Members: Age 0-21 _____ Age 22-64 _____ Age 65+ _____ **TOTAL** ___________________________

INCOME

Total Monthly household income?	$___________________	Have you applied or receiving any other services?
Balance of ALL checking accounts?	$___________________	Medicaid _____Yes _____ No
Balance of ALL savings accounts?	$___________________	Foodstamps _____ Yes _____ No
TOTAL	$ __________________	Charitable organization _____ Yes _____ No

EXPENSES

Rent/Mortgage	$___________________	Please explain any other expenses or type of assistance.
Utility/Phone/Heat	$___________________	____
Food	$___________________	____
Personal/Clothing	$___________________	____
Child Care	$___________________	____
TOTAL	$___________________	____

IN YOUR OWN WORDS PLEASE DESCRIBE YOUR CURRENT FINANCIAL SITUATION

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I believe that I am a low income user of home medical equipment which was supplied by Prism Medical Products, LLC. I understand that I am responsible for the co-insurance, non-deductible portion of my Medicare and/or private insurance coverage. I represent to Prism Medical Products, LLC that if I were required to pay my co-insurance portion of the monthly equipment rental/purchase, I would have to deny myself the needed medical equipment services. I understand the information provided herein will be used to determine my eligibility for hardship assistance from Prism and shall not be sold, distributed or used in any other way or for any other purposes.

Patient Signature ____ Date ______________________