Dear Patient:

In order to process any reduction of out-of-pocket expense amounts toward co-insurance, deductibles, or visit co-payments under the Financial Assistance Program, it is necessary that you complete the enclosed application in full, sign, date, and return it to your treating clinic, email to pcoleman@phx-pt.com, or on our website, https://phoenixphysicaltherapy.com/patient-billing-medical-records/.

Please complete the attached application in full; including income earned by all members of your household. If you are a full-time student and are claimed on your parent's income tax, please include their income. Failure to supply income verification or an incomplete application will result in your application being denied.

REQUIRED DOCUMENTS - WHAT TO INCLUDE WITH YOUR APPLICATION:

Proof of income can be provided in **one or more** of the forms listed below:

- Three recent months' worth of paystubs or unemployment
- Official letter from your employer that includes hourly wage and hours worked. The letter must have date, employer's name, address, and phone number.
- If you are self-employed, please provide a letter explaining your monthly gross income. The letter must include your name, address, phone number and copy of last year's taxes.
- If you are receiving state, county, or personal assistance, please provide a letter of support or award letter from program in which you are enrolled.
    - Letter of support must indicate the name of the person's name who is providing the support and what support is being provided.
- Provide social security award letter for the current year form SSA-1099
- Provide proof of pension form 1099-R Distribution from Pensions, Annuities, Retirement or Proof Sharing Plans, IRAs, Insurance Contracts.

Also, please include the following:

- Federal Income tax return for the current year **OR**

- Three months of bank statements, if your income has changed since the most recent tax filing. (checking, savings, money market, holiday clubs, etc.)

Note: If you do not have a tax return for the current year, you must provide the last 3 months of complete banking information. (checking, savings, money market, holiday clubs, etc.)

Any missing documents may result in a delay in processing or denial of your application. Thank you for your cooperation.

If we may be of further assistance, please call (303) 546-9158 ext. 320 before completing your Financial Assistance application.

Sincerely yours,

Financial Assistance Program

COMPLETION OF FINANCIAL Assistance PROGRAM APPLICATION

1 & 2 PATIENT NAME AND ADDRESS – Should be printed last name, first name, and current mailing address.
PHONE NUMBER – The telephone number of the person seeking assistance through the program.

EMPLOYER INFORMATION – Applicant and/or spouse's employer information must be included.

FAMILY INCOME – A list of combined gross income before taxes for the applicant and all other family members listed in #7. For more information about income documentation, see the cover letter.

PATIENTS WITH NO INCOME SOURCE will need to provide a letter giving their name and explaining why they are requesting Financial Assistance. This letter must explain how they are supported. It should be signed by whomever is supporting the applicant or, if necessary, the applicant themselves.
EXAMPLE: My name is XX and I am providing XX with room and board. He has no income and is unable to pay his medical bills. He has no income for XX months. Any assistance you can provide in resolving his medical expenses will be appreciated.

IF THE APPLICANT IS NOT A UNITED STATES CITIZEN, then a copy of their Resident Alien card must be included, or a copy of immigration papers reflecting refugee status.

FAMILY INFORMATION – Include those family members related by birth, marriage, or adoption that live together, and are legally responsible for debts incurred by another household member or are named on a filed United States income tax return for the year as a dependent.

SIGNATURE – Application must be signed and dated by the applicant. Any unsigned application will be denied.

Please submit completed Financial Assistance Program Application, Family Cash Resources form, and any supporting documentation to your treating clinic, email to pcoleman@phx-pt.com, or on our website, https://phoenixphysicaltherapy.com/patient-billing-medical-records/.

If you believe that you may be eligible for a reduction you may make a request for services by completing the Financial Assistance Program Application. The Phoenix Physical Therapy Financial Assistance Program RCM representative will make a written conditional or final determination of your eligibility for uncompensated services. To be eligible to receive Financial Assistance, your family income must be at or below the following levels:

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA				
Person(s) in family/household	**Category A 100% Reduction**	**Category B 75% Reduction**	**Category C 50% Reduction**	**Category D 25% Reduction**
1	$14,580	$29,160	$43,740	$58,320
2	$19,720	$39,440	$59,160	$78,880
3	$24,860	$49,720	$74,580	$99,440
4	$30,000	$60,000	$90,000	$120,000
5	$35,140	$70,280	$105,420	$140,560
6	$40,280	$80,560	$120,840	$161,120
7	$45,420	$90,840	$136,260	$181,680
8	$50,560	$101,120	$151,680	$202,240
For families/households with more than 8 persons, add $4,720 for each additional person for Category A, $9,440 for Category B, $14,160 for Category C, $18,880 for Category D.				

https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Financial Assistance Form

PATIENT INFORMATION	
Patient Name:	
Street Address:	
City, State:	Zip Code:
Home Phone:	Cell:

EMPLOYMENT INFORMATION	
Employer:	
Employer Address:	
City, State:	Zip Code:
Phone:	Occupation:
Spouse's Employer:	
Spouse's Employer Address:	
City, State:	Zip Code:
Phone:	Occupation:

MONTHLY INCOME	
Monthly Family Income:	Total Annual Family Income:
Wages/Self-Employment:	Unemployment/ Worker's Compensation:
Public Assistance:	Social Security (wages only):
Alimony and/or Child Support:	Pension, Dividends, Interest, Rental Income:
Money Market/Annuity Draw:	Other Income:

FAMILY INFORMATION (LIST ALL FAMILY MEMBERS IN YOUR HOUSEHOLD)	
Name	Relationship & Age
Total Family Members (including applicant):	*use additional sheet if necessary

8. I certify that the above information is true and accurate to the best of my knowledge. If appropriate, I will apply for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my charges, and I will take any action necessary to obtain such assistance and will assign or pay to CACC Physical Therapy the amount recovered for charges. I further understand that the information which I submit concerning my annual family income and family size is subject to verification by CACC Physical Therapy. I also understand that if any information I have given is determined to be false, such a determination will result in a denial of providing services as uncompensated care or reductions in co-payments and I will be liable for the charges of the services provided.

Date of Request

Applicant's Signature