TeleCARE
REMOTE CARE SERVICES

Financial Hardship & Cost-Sharing Waiver Request

Patient Name: _____ **Date of Birth:** _____

Account / MRN: _____ **Date:** _____

Purpose of This Form

This form is used to request a waiver or reduction of patient cost-sharing amounts based on financial hardship. The clinic does not routinely waive cost-sharing and evaluates each request individually, in good faith, and without advertising or solicitation.

Patient Financial Hardship Attestation

I attest that I am currently experiencing financial hardship and believe that my household income is at or below 300% of the Federal Poverty Guidelines. I understand that this attestation is relied upon by the clinic in good faith.

Household Size: _____

Estimated Annual Household Income: $ _____

I understand that I am not required to submit tax returns, bank statements, mortgage records, or similar documentation unless specifically requested, and that this request is based on trust and good-faith disclosure.

Patient Signature: _____ Date: _____

Clinic Determination (Staff Use Only)

☐ Approved ☐ Partially Approved ☐ Denied

Waiver Effective Dates: From _____ To _____

Reviewed By (Name/Title): _____

Signature: _____ Date: _____

Compliance Statement

This waiver is granted in accordance with federal guidance permitting individualized determinations of financial need. The clinic does not routinely waive cost-sharing, does not advertise such waivers, and makes determinations on a case-by-case basis after reasonable consideration of the patient's circumstances.