CHESTNUT HEALTH SYSTEMS
CHESTNUT FAMILY HEALTH CENTER

Patient Income Eligibility Exception Waiver Application

Patient Name:_____ Patient DOB:_____

Program Name:_____

TO BE FILLED OUT BY RESPONSIBLE PARTY*:* ***(Please provide proof of income)***
The reason I need financial assistance is as follows:

_____

_____

_____

_____

_____

_____

_____ _____
Patient/ Responsible Party Printed Name **Responsible Party Relationship to Patient**

_____ _____
Date **Patient/Responsible Party Signature**

TO BE FILLED OUT BY CHESTNUT FAMILY HEALTH CENTER STAFF ONLY:

Annual Income:_____ **No. of Dependents:** _____ **Current Co-pay:** _____

This patient meets the exemption criteria to qualify for waived fees because:

____**1.** A dependent adult whose spouse or other responsible party is unwilling to assume financial responsibility or the cost of treatment.

____**2.** A dependent minor who is not Medical Benefits, All Kids and Family Care eligible and/or whose parent(s) or legal guardian is unwilling to assume financial responsibility for the cost of treatment.

____**3.** A pregnant woman who is not Medical Benefits, All Kids and Family Care eligible and has no insurance benefits that cover the cost of treatment.

____**4.** A member of a family unit whose combined debt for prior medical expenses (not covered by insurance) exceeds 7.5 % of the total gross family income. (Attach copies of prior medical bills)

____**5.** A patient with an extenuating circumstance that meets any additional hardship guidelines.

____**6.** An individual for whom the fee is the sole inhibitor to accept treatment.

Suggested CoPay: _____ **Effective Date:**_____

Comments:

_____

_____

☐ Approved ☐ Denied

_____ _____
Program Manager Signature **Date**

Chestnut Family Health Center

Estimated Expense Record

Description	Monthly Expense
Housing:	
Rent or Mortgage	
Heating (Gas)	
Electricity	
Telephone/Cell Phone	
Cable TV/Internet	
Renters or Homeowners Insurance (if not included in mortgage)	
Water/Sewage/Trash	
Transportation:	
Car Payment	
Gas	
Car Insurance	
Other Insurance:	
Health (Medical & Dental, if not payroll deducted)	
Life	
Disability	
Child Care:	
Child Care or Babysitters	
Child Support or Alimony	
Food:	
Groceries	
School Lunches	
Medical Bills:	
Doctor	
Dentist	
Prescriptions	
Other Medical (Specify):	
Education:	
Tuition	
Other School Expenses	
Other Indebtedness:	
Credit Cards	
Personal Loans	
Home Equity Loans	
Other (Specify):	
Total Monthly Expenses	
Total Annual Expenses	

Patient Name:_____ Patient DOB:_____