



## Patient Financial Assistance Program Application

Harmonious Living Chiropractic: Fitness & Wellness Center is committed to providing quality and affordable healthcare services. We strive to provide financial assistance as needed, based on the patients' ability to pay for services. Our *Patient Financial Assistant Program* is created to ensure assistance is provided to patients who demonstrate a financial need and to ensure Harmonious Living Chiropractic: Fitness & Wellness Center remains in compliance with all Federal and/or State regulations regarding financial assistant. Patients who qualify for financial assistance will not be billed more than the our normal fees (NF) to an insured patient.

The patient must complete a *Financial Statement Form* and provide documented proof of income to be considered for our *Patient Financial Assistance Program*.

**Documentation of Financial Hardship:** Appropriate document for hardship would be one or more of the following:

1. Documented proof that the patient is at or below 200% of the current federal poverty guidelines (see *2023 Guidelines*). Acceptable documents include:
  - a. W-2 withholding statements
  - b. Pay check stubs
  - c. Income tax return (recent)
  - d. Forms from Medicaid or other State-funded medical assistance
  - e. Forms from employers or welfare agencies
2. Patient has other circumstances that indicate financial hardship. These may include situations such as:
  - a. Proof of bankruptcy settlement
  - b. Catastrophic situations (e.g. death or disability in family, divorce)
  - c. Other documentation that shows that the patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses.

**Annualization Process:** Income shall be annualized from the date of request based on the documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to the patient income.

**Denial of "Financial Assistance ":** Any denial of financial assistance request will be written and will include instructions for reconsideration. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered per the above guidelines.

**No Guarantee:** The completion and submission of this application does not mean your request will be granted, guarantee approval, or that you will be relieved of financial responsibility.

**All information relating to financial hardship request will be kept confidential.**

**Harmonious Living Chiropractic: Fitness & Wellness Center, LLC**  
10 South Street, Suite 403, Baltimore, Maryland 21202  
Phone: 240-264-6372 | Fax: 1-888-375-5167  
[www.driffanybutler.com](http://www.driffanybutler.com)

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### Financial Disclosure

Financial Hardship Information Needed. HHS Poverty Guidelines-Used to determine financial hardship based on income to assess eligibility for acceptance into the *Patient Financial Assistance Program*.

#### **2023 HHS Poverty Guidelines**

#### **2023 Poverty Guidelines for the 48 Contiguous States and the District of Columbia**

Persons in Family/Household	Poverty Guidelines	200% of Poverty Guideline (OCS/CED)
1	\$14, 580	\$29, 160
2	\$19, 720	\$39, 440
3	\$24, 860	\$49, 720
4	\$30, 000	\$60, 000
5	\$35, 140	\$70, 280
6	\$40, 280	\$80, 560
7	\$45, 420	\$90, 840
8	\$50, 560	\$101, 120

For families/households with more than 8 persons, add \$5, 140 for each additional person. Then multiply by 2.00 for 200% of Poverty Guidelines (for OCS/CED)

**Supportive Documents:** Please provide the following information so we may complete your application:

- Most recent IRS tax forms (1040 and/or W-2) (Must be signed)
- Check stubs for the past 30 days for all persons employed in the home
- Unemployment check stubs for the past 30 days
- Drivers license or identification card for adults
- Proof of all other income received in the past 30 days
- Proof of all outstanding bills (payment stubs, cancelled checks, etc.)
- DSHS Denial letter
- Medicaid forms or card
- Attached *Financial Statement* (completely filled out and signed)

Be sure to sign the attached *Financial Statement*. Your request will not be processed if the *Financial Statement* is not signed.

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### Financial Statement

#### Patient/Guarantor Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_

Guarantor Address: \_\_\_\_\_

**Note: If you are married, your spouse's financial information and signature is required to process your application.**

#### Spouse Information

Spouse Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Guarantor Address: \_\_\_\_\_

#### Household Information

Number of Dependents: \_\_\_\_\_ Total Monthly Household Income: \$ \_\_\_\_\_

*Note: This should be income at this time to account for a layoff or other type of employment change. Total household income includes the following for all members of your household: Gross Salary (income before taxes), Unemployment Compensation, Disability and Workers' Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.), and Other Income.*

#### Acknowledgement

*I hereby acknowledge the above information is true and correct. I understand that I will be notified by Harmonious Living Chiropractic: Fitness & Wellness Center if: 1) I do not qualify for assistances, or 2) I do not qualify, in which Harmonious Living Chiropractic: Fitness & Wellness Center will provide details on any above discount. I authorize Harmonious Living Chiropractic: Fitness & Wellness Center to verify the information I provided for the sole purpose of assessing financial need, including by seeking appropriate documentation. I understand that if I do not qualify for assistance, Harmonious Living Chiropractic: Fitness & Wellness Center will bill me at the applicable rate. I hereby acknowledge that I am neither related to, nor employed by, the doctor who prescribed care at this office.*

Patient/Guarantor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Mailing Instructions/Contact Information

**Please submit completed application and all necessary supportive documents to:**

Harmonious Living Chiropractic  
PO Box 558  
Columbia, Maryland 21045

For additional support, questions, etc. contact us at (240) 264 – 6372.

**Note: Please allow 4 – 6 weeks for processing.**

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#### DO NOT WRITE BELOW THIS LINE – FOR INTERNAL USE ONLY

Date Received: \_\_\_\_\_ Staff Initials: \_\_\_\_\_ | Status:  Approved  Denied Staff Initials: \_\_\_\_\_

Signature of Clinical Director: \_\_\_\_\_ Date: \_\_\_\_\_

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