TRANSCEND MEDICAL
Going Beyond The Limits

800-403-3740

256-259-1498 FAX

Financial Hardship

The patient will need to complete a financial disclosure from and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

Documented proof that patient is at or below 200% of the current federal poverty guidelines. This can include documents such as

- ☐ W-2 withholding statements (most resent IRS Tax form 1040 /W2 must be signed)
- ☐ Pay Check stubs (past 30 days) or unemployment checks
- ☐ Income Tax return (most resent IRS Tax form 1040 /W2 must be signed)
- ☐ Form from Medicaid or other State –funded medical assistance (cards or forms)
- ☐ Forms from welfare agencies.
- ☐ Proof of Bankruptcy settlement
- ☐ Catastrophic situation (death, disability etc.)

***ALL Information relating to financial hardship requests will be kept confidential*.**

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
1	$14,580
2	$19,720
3	$24,860
4	$30,000
5	$35,140
6	$40,280
7	$45,420
8	$50,560
For families/households with more than 8 persons, add $5,140 for each additional person.	

WWW.HHS.GOV

Patient Name: _____ Date: _____

Name of Responsible Party: _____

Relationship: _____ Spouse: _____

Telephone: _____ Cell : _____

Address _____

Number of Family Members (Living in Household): _____

Employer: _____ Address: _____

Unemployed _____ How Long _____ Spouses Employer: _____

Other Income Sources: _____

Monthly Salary (Gross) $ _____

Public Assistance $ _____

Unemployment $ _____

Social Security $ _____

Workman's Comp $ _____

Child Support $ _____

Other $ _____

Total Family Incomes $ _____

I Hereby acknowledge that the information given herein is true and correct. I authorize Transcend Medical to verify any information contained in this document for the sole purpose of assessing financial need

Signature of Person Making Request _____ Date: _____

Signature of Spouse/Other: _____ Date: _____

Received by/Approved by: _____ Date: _____

Good for 1 Year from Date approved