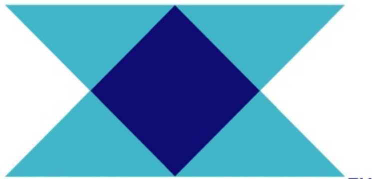

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FINANCIAL HARDSHIP WORKSHEET

Value Care Health Clinic requires that the Financial Hardship /Zero Income worksheet be completed by all families who are requesting a reduction or waived co-pay, co-insurance and or deductible due to our legal obligation within our insurance contracts to collect portions deemed patient responsibility.

Applicant/Participant Name:____ ID:_________________________

Date of Review:______________ Review Completed by: ____

Applicant/Participant Income Information

1. Does anyone (other than applicant/participant family) make contributions to your household in the form of cash (money for food, clothing, cars, internet etc.) and/or products (purchases of food, grooming products, cigarettes, etc)? ☐ Yes ☐ No

2. If yes, complete the table below.

Item Contributed	Who Made the Contribution	Cash Amount or Value of the Contribution
		$
		$
		$
		$
		$
	TOTAL	$

3. Have you applied, been approved and/or do you receive benefits from any of the following programs?

Programs/Benefits	Applied Yes or No	Approved Yes or No	Currently Receive Benefits Yes or No	Amount of Benefits Per Month
Public Assistance				$
Social Security				$
SSI				$
Unemployment				$
Welfare				$
Child Support				$
Alimony				$
Pension/Annuity				$
Food Stamps				$
Other				$

4. If you have applied for benefits, what is the status of the application?

____

Vehicle Information

5. Do you have the use of or own a car(s)? ☐ Yes ☐ No If yes, complete the information below.

Vehicle Number 1: Make:________________ Model No:____________ Year:__________

☐ ☐ ☐

Own Lease Rent

Vehicle Number 2: Make:_________________ Model No:_____________ Year:__________

Own ☐ Lease ☐ Rent ☐

Weekly Expenses

6. How much do you spend a week on the following?

Item	Weekly Expense	Method of Payment
Food		
Paper products		
Personal grooming products		
Cleaning products		
Car payments		
Car use and maintenance costs		
Transportation costs (if no car is owned)		
Cable TV		
Internet		
Entertainment (movies, lottery, sporting events, video rental, vacations etc)		
Clothing		
Cigarettes/Cigars		
Telephone (home)		
Cell phone		
Utilities		
Mortgage or rent		
Unreimbursed medical expenses		
Unreimbursed child care expenses		
Unreimbursed job expenses		
Charitable contributions (church, charity etc)		
TOTAL		

Please provide your last two pay stubs, driver's license, and social security card as part of your financial review. Thank you

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APPLICANT/PARTICIPANT CERTIFICATION

I certify that the above estimates provided by me are true to the best of my knowledge. I understand that willful misrepresentations of the facts are grounds for disqualification for assistance.

_______________________________ _______________________________

Applicant /Participant Signature Date

_______________________________ _______________________________

VCHC Staff Member Date