Value Care Health Clinic™
1050 S. Academy Blvd. Suite 140
Colorado Springs, CO 80910
P: (719)574-7083
F: (719) 574-1226

# 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. How many people are in your house hold _____?
3. If yes, complete the table below.

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

4. 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 | | | | $ |

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

_____

_____

## Vehicle Information

6. 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

7. 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**

Are you currently employed: YES, NO Unemployed Since? _____

Current Pay: $_____every: Week Bi-Weekly Month Year

Spouse employed? YES, NO Unemployed Since: _____

Spouse's Current Pay: $_____every W e e k Bi-Weekly Month Year Living Situation: Homeless Own Home Rent Other:_____

---

**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