Provider Name: _____
2026 Financial Hardship Waiver Application

Name: _____ DOB: _____ *Household Monthly Income*: $_____

2026 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in Family	Poverty Guideline
1	$ 15,960
2	$ 21,640
3	$ 27,320
4	$ 33,000
5	$ 38,680
6	$ 44,360
7	$ 50,040
8	$ 55,720
For families with more than 8 persons, add $5,680 for each additional person.	

Fee Reduction Guidelines

Gross monthly income % of current federal poverty level	Percentage fee reduction	
	minimum	maximum
Over 450%	0%	0%
400 to 450%	0%	20%
300 to 400%	20%	40%
250 to 300%	40%	60%
200 to 250%	60%	80%
Less than 200%	80%	100%

Calculations:

A. Number of Dependant Persons in Family: _____

B. Household Monthly Income x 12 =
Annual Income of $_____

C. Annual Income $_____ divided
by Poverty Guideline $ _____
= _____ x 100 =_____ % of Federal Poverty Guidelines.

D. Eligible fee reduction percentage: _____%

E. Percentage to be paid: 100% - _____% (D above) = **_____%**

F. I have health insurance with: _____

My actual deductible amount is $_____
I have met a total of $_____

My actual co-payment $ _____ per visit,
or
My actual co-insurance is _____% per visit.

By signing below, I acknowledge that:

1) I have been informed of the usual and customary fee for the services rendered by the below named provider. I have been advised that it is the policy of this office to collect directly from me all amounts not paid by my insurance company, including co-payments and deductibles for which I am responsible. However, to do so, would cause me and/or my family financial hardship based upon the preceding information.

2) I still desire and need treatment. Based upon my ability to pay for these services, as discussed with the provider named below, I agree to the following agreement. I agree to pay a reduced fee of **_____% (from Item 'E' above)**

Deductible $_____ X _____% = **$ _____**

Co-payment $_____ per visit X _____% = **$ _____** , or Co-Insurance of _____ per visit X _____% = **$ _____**

3) I affirm that the statements made herein are true and correct to the best of my knowledge. I agree to pay the scheduled fees at the time of treatment.

4) I understand that this *'Financial Hardship Waiver'* expires one year from the date of the signature below, or if my financial status changes, whichever comes first.

_____
Patient Name

_____
Address

_____
City, State and Zip Code

_____
Daytime Phone #, Evening Phone #

_____
Responsible Party Name Relationship to Patient

_____
Responsible Party Signature **Date**

_____
Driver's License Number (or State Identification Number)

_____
Provider Signature **Date**