ON WITH LIFE
FINANCIAL HARDSHIP APPLICATION 2025

PERSON SERVED INFORMATION			
Name:	**DOB:**	**Social Security Number:**	
Home Address:	**City:**	**State:**	**Zip**:
Home Phone:	**Cell Phone:**	**Email Address:**	
Name of Person Completing Form (if not patient):	**Relationship to Patient:**	**Phone Number:**	

Information is based on total household income including income from any related individuals residing in the same home.

Please submit the applicable required documents for all related members in the household with this form, financial hardship cannot be assessed without them and will be denied.

Appropriate documentation of financial hardship requires the following:

Income and Assets Documentation, including:

- Last 3 months of check stubs or W-2
- Last 3 months bank statements, investment reports
- Last 3 months disability benefit letter
- Decree for child support
- Tax Return

Evidence of additional circumstances that indicate financial hardship, such as:

- Proof of outstanding debts (copies of bills, statements; late notices, etc.)
- Proof of bankruptcy settlement (if applicable)
- Catastrophic situations (death or disability in family, divorce) or other documentation which demonstrates the patient would be unable to pay medical bills and still be able to pay for other basic necessary expenses.

Additional items may also be requested.

Number of Dependents in Household (including applicant):	**Date(s) of Service:**
_____ Adults _____ Children under 18	

Type of Assistance Requested:	_____ Reduced Deductible _____ Discounted Cash Services _____ Reduced co-pay/co-insurance _____ Forgiveness of Debt

HOUSEHOLD EMPLOYMENT INFORMATION

Attach copies of page 1 & 2 if needed

Patient/Guarantor #1	Spouse/Family Member #2
☐Employed ☐Unemployed ☐Retired As Of: _____ **Employer** (Include Name & Address):	☐Employed ☐Unemployed ☐Retired As Of: _____ **Employer** (Include Name & Address):

HOUSEHOLD FINANCIAL DATA

Attach copies of page 1 & 2 if needed

INCOME	**Applicant** (per month)	**Co-Applicant** (per month)	**Combined Income** (per month)
Gross Wages, before taxes			
Social Security			
Disability Insurance			
Unemployment			
Spousal/Child Support			
Rental Property Net			
Interest/Dividends			
Self Employed Net			
Pension/Retirement			
Other Income			
TOTAL INCOME ALL SOURCES:			

ASSETS	**Applicant**	**Co-Applicant**	**Combined Assets**
Cash on hand			
Checking Account(s) balance			
Savings Account(s) balance			
Mutual Funds current value			
Stocks/Bonds/CD's Current Value			
Primary Residence Assessed Value			
Other Property Assessed Value			
Auto #1 Value – make, model, yr			
Auto #2 Value – make, model, yr			
Recreational Vehicle(s) est. value			
Cash value of life insurance			
Cash value of pension			
TOTAL ASSETS ALL SOURCES			

EXPENSES	**Applicant** (per month)	**Co-Applicant** (per month)	**Combined Expenses** (per month)
Rent/Mortgage Payment			
Utilities (electric/phone/gas/water)			
Insurance (medical, car, home, life)			
Food/Clothing			
Medical Obligations (hospital, clinic)			
Medications			
Child Care/Child Support			
Credit Card Payments			
Loan Payments (bank, school)			
Other Expenses			
TOTAL EXPENSES ALL SOURCES			

Please describe other circumstances support your financial hardship:

_____

_____

_____

_____

PERSON SERVED ACKNOWLEDGEMENT & SIGNATURE

I certify that the information I have provided is true and correct to the best of my knowledge. I understand that providing any false or misleading claims, statements or documents as well as any concealment of a material fact will result in immediate cancellation of any agreement previously made. I understand that I am obligated to notify On With Life of any significant change ($200 or more per month) to the information above.

Signature of Patient or Legal Representative:	**Date:**	**Relationship to Person Served:**

ON WITH LIFE
FINANCIAL HARDSHIP APPLICATION WORKSHEET

Staff Use Only

Staff Verification Use Only -- Income	
Applicant	**Co-Applicant**
____ 3 Months Check Stubs **OR** ____ W-2 ____ SSI/SSDI Monthly Benefit Letter ____ 3 Months of Bank Statements ____ Spousal/Child Support Decree ____ Tax Return ____ Investment Reports	____ 3 Months Check Stubs **OR** ____ W-2 ____ SSI/SSDI Monthly Benefit Letter ____ 3 Months of Bank Statements ____ Spousal/Child Support Decree ____ Tax Return ____ Investment Reports
Staff Verification Use Only -- Expenses	
____ Proof of outstanding debts (bills/late notices) ____ Proof of bankruptcy settlement (if applicable) ____ Catastrophic situation or other documentation shows patient is unable to pay.	____ Proof of outstanding debts (bills/late notices) ____ Proof of bankruptcy settlement (if applicable) ____ Catastrophic situation or other documentation shows patient is unable to pay.

Eligibility is based on federal poverty guidelines for annual income, based on household.

2025 Federal Poverty Guidelines ***(Source: liheapch.acf.hhs.gov)***

Dollars Per Year

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	7,825.00	11,737.50	15,650.00	19,562.50	20,345.00	20,814.50	21,127.50	21,597.00	23,475.00	27,387.50	28,170.00	28,952.50
2	10,575.00	15,862.50	21,150.00	26,437.50	27,495.00	28,129.50	28,552.50	29,187.00	31,725.00	37,012.50	38,070.00	39,127.50
3	13,325.00	19,987.50	26,650.00	33,312.50	34,645.00	35,444.50	35,977.50	36,777.00	39,975.00	46,637.50	47,970.00	49,302.50
4	16,075.00	24,112.50	32,150.00	40,187.50	41,795.00	42,759.50	43,402.50	44,367.00	48,225.00	56,262.50	57,870.00	59,477.50
5	18,825.00	28,237.50	37,650.00	47,062.50	48,945.00	50,074.50	50,827.50	51,957.00	56,475.00	65,887.50	67,770.00	69,652.50
6	21,575.00	32,362.50	43,150.00	53,937.50	56,095.00	57,389.50	58,252.50	59,547.00	64,725.00	75,512.50	77,670.00	79,827.50
7	24,325.00	36,487.50	48,650.00	60,812.50	63,245.00	64,704.50	65,677.50	67,137.00	72,975.00	85,137.50	87,570.00	90,002.50
8	27,075.00	40,612.50	54,150.00	67,687.50	70,395.00	72,019.50	73,102.50	74,727.00	81,225.00	94,762.50	97,470.00	100,177.50
9	29,825.00	44,737.50	59,650.00	74,562.50	77,545.00	79,334.50	80,527.50	82,317.00	89,475.00	104,387.50	107,370.00	110,352.50
10	32,575.00	48,862.50	65,150.00	81,437.50	84,695.00	86,649.50	87,952.50	89,907.00	97,725.00	114,012.50	117,270.00	120,527.50
11	35,325.00	52,987.50	70,650.00	88,312.50	91,845.00	93,964.50	95,377.50	97,497.00	105,975.00	123,637.50	127,170.00	130,702.50
12	38,075.00	57,112.50	76,150.00	95,187.50	98,995.00	101,279.50	102,802.50	105,087.00	114,225.00	133,262.50	137,070.00	140,877.50
13	40,825.00	61,237.50	81,650.00	102,062.50	106,145.00	108,594.50	110,227.50	112,677.00	122,475.00	142,887.50	146,970.00	151,052.50
14	43,575.00	65,362.50	87,150.00	108,937.50	113,295.00	115,909.50	117,652.50	120,267.00	130,725.00	152,512.50	156,870.00	161,227.50

The amount of discount will range from 0% to 100% of the amount due on the account, based on a sliding scale determined by their annual income as it relates to the federal poverty guidelines.

Poverty Level	Discount Applied	Poverty Level	Discount Applied
At or below 150%	100%	226-240%	40%
151-165%	90%	241-255%	30%
166-180%	80%	256-270%	20%
181-195%	70%	271-285%	10%
196-210%	60%	286-400%+	0%
211-225%	50%		

Results of Initial Application

Reviewed by:

Application Received Date:	**Service Dates Effective For:**
____ Approved ____% discount approved	Denied Reason: ____ Missing POA ____ Income too high ____ Incomplete form ____ Verifications Other:

Approved/Denied by: ____ CFO ____ Administrator ____ Executive Director ____ Other:

Signature: Date: