Financial Hardship Program Guideline

Complete and return the Financial Hardship Application to Byram Healthcare:

Byram Healthcare
Attn: Financial Hardship Advocate
3010 Woodcreek Drive; Suite A
Downers Grove, IL 60515

Please provide the following supporting documentation (as applicable) with this application:

- Completed Byram Financial Hardship Application – Attachment B
- Copy of your most recent Federal Income tax return(with W-2s, 1099s)- Must be signed
- If household income is close to or below the poverty level, documentation that State Medical assistance has been applied for and denied.
- If homeless, letter from the county office.

Eligibility

- Financial Hardship assistance can only be approved for either a six (6) month period or for one (1) year and is based upon the applicant's eligibility and information submitted in the Financial Hardship Application.
- Customers applying for financial assistance due to unemployment will, if eligible, be granted assistance for a period not to exceed 6 months. Re-application to the Byram Healthcare Financial Hardship Program will be necessary for continued financial assistance. This does not apply to those who are unemployed based upon permanent disability.
- All information presented on the application may be verified through credit bureaus prior to any decisions Byram Healthcare may make regarding an applicant's qualification for the Financial Hardship Program.

Byram Healthcare reserves the right to modify the customer Financial Hardship Program at any time and may change or discontinue any assistance at any time without notice.

Complete and return the Financial Hardship Application to Byram Healthcare:

Byram Healthcare
Attn: Financial Hardship Coordinator
3010 Woodcreek Drive; Suite A
Downers Grove, IL 60515

Byram Healthcare abides by the contractual and legal obligations of Medicare, Medicaid and any other governmental or commercial third party payer or regulatory agency to collect charges, co-payments, co-insurance and deductible amounts owed by patients. Recognizing that circumstances may arise whereby an individual is unable to meet his or her financial obligations for services rendered, we have adopted a policy of screening requests for discounts, delayed payment plans and/ or forgiveness of debt based on individual circumstances. To do this, we must obtain certain financial and other personal information from you which will be considered and applied consistently in accordance with our established financial assistance protocol.

Please provide the information and documents listed below for each adult family member living in your household (and reported on your income tax return) to the best of your ability. All the information provided will be held confidential according to our privacy policy.

APPLICANT INFORMATION

Applicant Name: _____

Patient Name (if different than applicant): _____

Phone (Home): _____Phone (mobile): _____Email: _____

Address: _____

_____

Patient Date of Birth: _____ # of Family Members in Household _____

Year of Tax Return (most recent year of federal tax return must be attached to application) _____

I certify under the penalty of perjury that all of the information provided as a part of this financial assistance application is true and accurate. I understand that the information supplied in this application is subject to verification by Byram Healthcare and hereby authorize any holder of information supplied in this application to release such information to Byram Healthcare for purposes of this application. I further understand that failure to disclose information requested in this application or disclosure of erroneous information will cause the application to be denied. I also agree to apply for state or federal assistance prior to an award of financial assistance, if applicable. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by Byram Healthcare to take such action and will assign Byram Healthcare all amounts recovered up to the total amount of the outstanding balance on my bill.

_____ _____

Applicant Signature Date

_____

Relationship to Applicant (if not Applicant)

Attachment B