Financial Hardship/Payment Reduction Application

National Seating & Mobility (NSM) is required by regulation to collect co-insurance or deductibles due from our clients. Recognizing that in limited circumstances, a person might not be able to afford that payment, NSM is required to obtain documentation to support the inability to pay on file. Please fill out the following information as completely as possible. At NSM's discretion, we may use this information to make a determination of your ability to pay. NSM may choose to reduce or waive your co-insurance or deductible, make payment arrangements or elect not to reduce or waive any amount. NSM retains the right to modify or discontinue this program at any time without prior notification. Reduction or waiver does NOT apply to any non-covered items.

Client Name		Work Order Number:	
Spouse/Parent/Guarantor (if applicable)		Item to be reduced:	
Address		☐ Co-Insurance	
City State ZIP		☐ Deductible	
Phone/Fax		☐ Other: (please list below)	
Email			

HOUSEHOLD/EMPLOYMENT INFORMATION

Number of Household Members:			
Applicant Employer:		Annual Income:	
Spouse/Parent/Guarantor Employer:		Annual Income:	
Income from Other Household Members:		Annual Income:	
Other Income:			
Other Income:			

NET MONTHLY EXPENSES

Expense	Monthly Amount	Expense	Monthly Amount
Rent/House Payment		Child Support	
Auto/Truck Payment		Life Insurance	
Auto Insurance		Property Insurance	
Utilities (electric, phone, gas, water)		Credit Card Payment	
Food/Groceries		Other (please list)	
Loan Payment (bank, student loans)			
Prescriptions/Medical			
Health/Dental Insurance			

ASSETS/RESOURCES

Household Member	Type	Value
	Checking Account	
	Checking Account	
	Savings Account	
	Savings Account	
	Other (CDs, stocks, bonds, money market accounts, etc.)	

DOCUMENTATION REQUIREMENTS – MUST BE ATTACHED TO APPLICATION

(Please attach copies. Do not submit original documents.)

Income Documentation:	W-2 or unemployment check stub/statements for the past 90 days Most recent check stub/statement for all persons employed in the household Proof of other income received in the past 90 days Forms/letters from employers or assistance agencies Income tax return Forms from Medicaid or other State-funded medical assistance
Evidence of additional circumstances that indicate financial hardship, such as:	Proof of outstanding debts or bills (copies of statements, late notices, etc.) Proof of bankruptcy, if applicable Evidence of catastrophic situations (death in family, divorce) or other documentation which demonstrates being unable to pay and still be able to pay for basic necessary expenses
Please describe any other situations or circumstances that support your financial hardship – use additional sheets if necessary:	

AGREEMENT

I understand that the information provided herein will be used to determine my eligibility for hardship assistance from National Seating & Mobility (NSM) and shall not be sold, distributed, our used in any other way or for any other purpose. I hereby attest that all information provided here is, to the best of my knowledge, accurate and complete and that any misrepresentation will result in the denial of assistance and the recovery of any amounts previously adjusted. Further, I understand that any assistance is limited to the current order(s) and that I must re-apply for assistance on any future orders, and that any change in financial circumstances must be immediately reported to NSM.

SIGNATURES

Client Signature		Guarantor Signature	
Print Name		Print Name	
Date		Date	

NSM STAFF USE ONLY

To be completed by Branch or Funding staff:	
Branch/Work Order Number:	
Total amount currently due from client :	
Amount due from client for covered items only: ***(non-covered items are not eligible for discount or waiver)***	
Was alternate funding (Care Credit, credit card, charitable organization, etc.) discussed with the client? Why was it not applied to payment due?	
Notes/Other information to be considered:	
To be completed by Compliance	
Date Received:	Date Returned to Branch:
Compliance Reviewer Comments:	

Hardship Verified? ☐ Yes ☐ No	If yes, amount due from client has been reduced to:	
Reviewer's Name/Title	Signature:	Date:
Appealed to Committee? ☐ Yes ☐ No	Committee Decision	Final Decision Date: