

Wings of Hope Financial Hardship Application for Waiver of Copayment, Deductible or Payment for Services

Wings of Hope’s Journeys Palliative Care program is committed to providing quality care to our patients. Our services are paid for by Medicare, Medicaid and private insurance. Please complete pages 2 – 4 of this application if either of the following situations apply to you:

- You do not have any health care insurance and cannot afford to pay out of pocket for these services
- You have health insurance but you cannot afford the copayment/deductible

All Financial Hardship Applications are confidential.

Poverty Guidelines for 2026*			
Persons in Family/Household	Poverty Guidelines		
	100%	200%	400%
1	\$15,960	\$31,920	\$63,840
2	\$21,640	\$43,280	\$86,560
3	\$27,320	\$54,640	\$109,280
4	\$33,000	\$66,000	\$132,000
5	\$38,680	\$77,360	\$154,720
6	\$44,360	\$88,720	\$177,440
7	\$50,040	\$100,080	\$200,160
8	\$55,720	\$111,440	\$222,880
For families/households with more than 8 people, add \$5,680 for each additional person in the 100% column.			

*Source:

<https://aspe.hhs.gov/sites/default/files/documents/b1bfa16b20ae9b89d525bc35de7c1643/detailed-guidelines-2026.pdf>

Percent of Services or Copayment to be Waived

- Patients whose family income is at or below 200% of the Poverty Guideline will be eligible for 100% to be waived.
- Patients whose family income is between 200% and 400% of the Poverty Guideline will be eligible for 75% to be waived.

Payments may also be waived all or in part due to other circumstances such as

- Proof of bankruptcy
- Catastrophic situations such as death, disability or divorce
- Paying for service/copayment means going without necessities such as heat

Wings of Hope Financial Hardship Application

Please provide us with the following information:

- Driver's license or identification card for adults
- Insurance card
- Attached application (pages 2 – 4 of this form)
- Proof of income
- Proof of expenses

Patient Name: _____

Date(s) of Service: _____

Name of Person Responsible for Patient: _____

Relationship to Patient: _____

Patient's Spouse: _____

Telephone Number: _____

Street Address: _____

City, State, ZIP: _____

of Family Member Living in Household: _____

Patient's Employer: _____

Employer Phone: _____

If Unemployed, How Long? _____

Spouse's Employer: _____

Employer Phone: _____

If Spouse Unemployed, How Long? _____

Other Family Members' Names, Employer and Employer Phone:

Monthly Family Income

Please Complete Fields That Apply

Source of Income	Amount Per Month
Monthly Salary (Before Taxes)	\$
Public Assistance Benefits	\$
Unemployment Benefits	\$
Social Security Benefits	\$
Worker's Compensation	\$
Child Support	\$
Other (Alimony, Etc.)	\$
TOTAL FAMILY/HOUSEHOLD INCOME PER MONTH	\$

Monthly Family Expenses

Please Complete Fields That Apply

Type of Expense	Amount Per Month
Mortgage/Rent	\$
Property Taxes	\$
Electricity	\$
Heat	\$
Vehicle Payment/Transportation Expense	\$
Groceries	\$
Insurance – Homeowner's	\$
Insurance – Vehicle	\$
Insurance – Medical/health	\$
Medications	\$
Medical Supplies	\$
Alimony	\$
Child Support	\$
Other	
Other	
Other	
TOTAL FAMILY/HOUSEHOLD EXPENSES PER MONTH	\$

Total amount of credit card debt: _\$ _____

Total amount of medical debt: _\$ _____

Have you experienced any of these in the last 6 months? Circle all that apply.

Bankruptcy Death Disability Divorce

If you pay for the deductible/copay, will that force you to go without necessities such as heat? Circle one.

Yes _____ No _____

I hereby acknowledge that the information given herein is true and correct. I authorize Wings of Hope to verify any information contained in this document for the sole purpose of assessing financial need.

Signature of Person Making Request _____ Date _____

Signature of Spouse/Other _____ Date _____

<p>For Office Use Only</p> <p>Document received on _____ (date)</p> <p>Received by _____ (Name & Title)</p> <p>Approved by _____</p> <p style="text-align: center;">Signature of Billing Specialist</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
