

Peninsula Kidney Associates
501 Butler Farm Road Suite I
Hampton, Virginia 23666

Application for Financial Hardship Waiver

Submission of this application is necessary to apply for a waiver of a claim due to substantial hardship. Only the applicant's proportionate share of the claim can be waived. All of the information requested in the application is voluntary; however, failure to completely and accurately provide the information may result in a denial of the waiver application. The principle purpose for which the information will be used is to assess an applicant's financial condition, to determine if hardship criteria apply to the applicant.

A. APPLICANT'S NAME (First, Middle, Last): Social Security Number: Driver's License ID: Date of Birth:

Mailing Address: City: State: Zip: Telephone (home & cell):

Applicant's Employer: Address: City: State: Zip: Telephone

B. SPOUSE'S NAME: (First, Middle, Last): Social Security Number: Driver's License ID: Date of Birth:

Mailing Address: City: State: Zip: Telephone (home & cell):

Spouse's Employer: Address: City: State: Zip: Telephone

C. Are there any unmarried children, or any other persons, living with the applicant? Yes () No ()

If yes, list their name, date of birth, and relationship to applicant.

Name (First, Middle, Last)	Date of Birth (mm/dd/yyyy)	Relationship to applicant
_____	_____	_____
_____	_____	_____

D. Estate consists of: List all estate assets including property conveyed through joint tenancy, living trust, annuities, life insurance policy, or retirement account. Please attach copies of mortgage statement or deed, and bank statements.

Property Market Value Mortgage Owed
\$ _____ \$ _____

Bank Accounts	Checking Balance	Savings Balance	Name & Address of Bank(s)	Account #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

E. Monthly Income.

Applicant's Net Salary (Attach two recent pay stubs) \$ _____
Spouse's Net Salary (Attach two recent pay stubs) \$ _____
Social Security/Retirement/Pensions/Annuities (Attach two recent s \$ _____
Disability Payments (Attach award letter or stub) \$ _____
Public Assistance \$ _____
Other Income (source): _____ \$ _____
Dividends, Interest, child support, alimony, commission

TOTAL INCOME \$ _____

I understand that the statements I have made on this application are subject to investigation and verification. I declare that the statements I have given on this form, to the best of my knowledge, are true and correct.

Signature of Applicant	Print Full Name	Telephone	Date
_____	_____	_____	_____
Signature of Spouse	Print Full Name	Telephone	Date
_____	_____	_____	_____

You will be contacted by the Billing Manager informing you of the application acceptance or decline. If approved, this application must be reviewed and updated on an annual basis while receiving treatment by the physician's of Peninsula Kidney Associates

FOR OFFICE USE ONLY
APPROVED OR DECLINED (circle)

Physician Signature	Date	Administrator's Signature	Date
_____	_____	_____	_____