Lincare
Powered Mobility™

In addition to filling out the Hardship Waiver you must provide a **copy of your household's last W-2 and/or copies of the household last 3 paychecks or some type of Proof of Income.** Otherwise we will **NOT** be able to review your request for financial hardship.

Please return this information along with the attached Hardship waiver as soon as possible.

Hardship Waivers are time sensitive and we will not be able to adjust your billing retroactively.

If you have any questions, please fill free to contact our billing department at 800-288-2031

Sincerely,

MRB Acquisition Corp./Lincare Powered Mobility
800-288-2031
1898 S. Clyde Morris Blvd
Suite 410
Daytona, FL 32119

Confidential Financial Hardship Worksheet

Valid for a maximum of 12 months (Re-application is necessary)

Patient name:
Patient Address:

Responsible party (if other than patient):

Customer equipment type (check all that apply):

☐ Oxygen ☐ Infusion Therapy
☐ Other Respiratory ☐ DME

FAMILY SIZE:
Number in household
Other dependents
(proof of income for all listed is required)

What is your current insurance information? Please list all medical insurance plans that you carry.

Primary: Secondary: Other:

Have you applied for Medicaid? (Y/N)

If you answered yes, please enter the estimated date your application for Medicaid will be processed:

INCOME: Please complete the financial information requested below. All information provided is strictly confidential and will be used only for purposes of determining financial hardship. In addition to the information requested below, you must provide a copy of the last W-2s and/or copies of the last three paystubs for proof of income for each member listed in the household count above. Without receipt of these documents, we will not be able to review your request for financial hardship. **Lincare reserves the right to perform upfront and/or intermittent verification of income and credit through an independent source.**

Monthly net income (After payroll deductions)		Monthly expenses (Do not include payroll deductions)	
Employment	$	Mortgage/rent	$
Unemployment/severance	$	Auto/transportation	$
Self-employment	$	Non-reimbursed work expenses (e.g., parking, tools)	$
Interest/dividends	$	Insurance (e.g., life, homeowners)	$
Pension/disability	$	Utilities (e.g., lights, water, gas)	$
Child support/alimony	$	Medications	$
Short-term disability	$	Childcare	$
Long-term disability	$	Credit cards	$
Rental income	$	Child support/alimony	$
State/Government financial ID	$	Personal property taxes (home, auto)	$
Other income: (List source)	$	Other expenses: (List name)	$
Other income: (List source)	$	Other expenses: (List name)	$
Total income	$	Total expenses	$

Patient name:

I certify that the above information is true and accurate and that this application is made to enable the medical supplier to judge my eligibility for reduced out-of-pocket medical expenses. The amount of financial assistance the medical supplier may grant will be determined based on the financial information and backup provided as well as the patient's individual situation. The medical supplier will inform you of the amount of financial assistance available. Please note that no more than 70% of your financial responsibility will be eligible for financial assistance, and any financial assistance granted will remain in effect for only 12 months. A new confidential financial worksheet must be filed with the medical supplier every 12 months.

I acknowledge that in addition to the financial assistance granted by the medical supplier, I will be responsible to pay not only my annual insurance and/or Medicare deductible but also other charges resulting from services provided to me-the patient.

Customer Signature Date

FOR INTERNAL USE ONLY

Account approved for % financial waiver of coinsurance.

Patient was previously approved for financial waiver of %, but has an open balance of $.

Location code: 90- - - Primary PR: Secondary PR:

Are there other observations or considerations that would support the patient's declaration of financial hardship?

Employee signature:
Center manager approval: Date:
Area manager approval: Date:
VP approval: Date:
RBCO approval (name/title): Date:

Charge Authorization Form

Customer name: Customer ID:
Location:
Location address:
Location city, state, zip:

I authorize (Lincare Powered Mobility) to debit my account indicated below for amounts not covered by my respective insurance coverage. I also authorize my depository financial institution to honor these transfers. This is an open authorization to allow debits to my account for amounts not covered by my insurance. I understand that such amounts may vary based on the services provided to me and my insurance coverage, but will not exceed $5,000 in any given month. This authorization is for a single-entry charge or recurring charges for services provided and billable. I acknowledge I will receive notice of the actual amount to be billed before the debit.

I certify that I am the authorized account holder for this account. This agreement will remain in effect until (Lincare Powered Mobility) receives my written notice of cancellation via mail.

Authorized account holder signature (required) Date (required)

Account holder name (print): Recurring ID:
Account holder address:
City, state, zip:

Select one of the following payment options:

☐ Credit or debit card – Enter the last four digits of your account number and expiration date

Visa®	4********	Exp. Date: /
MasterCard®	5********	Exp. Date: /
American Express®	3********	Exp. Date: /
Discover Card®	6********	Exp. Date: /

☐ Check draft – Select the type of account and complete the banking information

☐ Checking account ☐ Savings account

Bank name: Branch:
Routing number: Last four digits of account #:

Charge Authorization Form

If you have any questions with regard to the amount charged, or must notify us of your intent to cancel and/or revoke this authorization, please contact the billing office listed on your customer statement.