



Older Individuals who are Blind – Technical Assistance Center

HARDSHIP APPLICATION

PATIENT NAME: _____ BIRTHDATE: _____

NUMBER OF PEOPLE IN HOUSEHOLD: _____ AGES OF THOSE UNDER 18: _____

LIST ALL SOURCES OF HOUSEHOLD INCOME:

Table with 2 columns: Source (wages, social security, pension, etc) and Monthly Net Income. Includes dollar signs and blank lines for entries.

DO YOU RENT OR OWN YOUR HOME? RENT ___ OWN ___ MONTHLY PAYMENT \$ _____

LIST ALL OUTSTANDING DEBTS (auto loans, credit cards, doctor & hospital bills, child support, etc.)

Table with 3 columns: Description, MONTHLY PAYMENT \$, BAL \$. Includes blank lines for entries.

UTILITIES _____ MONTHLY PAYMENT \$ _____

PHONE _____ MONTHLY PAYMENT \$ _____

CABLE TV/INTERNET _____ MONTHLY PAYMENT \$ _____

OUT OF POCKET MEDICAL EXPENSES _____ MONTHLY PAYMENT \$ _____

HAVE YOU APPLIED FOR MEDICAID? YES _____ NO _____ IF YES, PLEASE PROVIDE THE STATUS OF YOUR APPLICATION _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I FURTHER CERTIFY THAT NO OTHER SOURCE IS RESPONSIBLE FOR PAYING THIS BILL.

Signature _____ Date _____

*** TO PROCESS THIS APPLICATION PLEASE INCLUDE THE FOLLOWING: ***

- Proof of income (paycheck stubs, tax return, Social Security Benefit Verification Letter, etc.)
- Copy of 2 most recent Checking and Savings Account Statements
- Proof of out of pocket medical bills
- Copy of Medicaid Card or Denial Letter (if applicable)
- Documentation of bankruptcy or catastrophic situation, such as death in family



Older Individuals who are Blind – Technical Assistance Center

STATEMENT OF NO INCOME

If you have **NO** monthly income, please read and sign the following statement:

I, _____, do not currently have any income, which includes but is not limited to wages, unemployment benefits, disability benefits, self-employment income, Social Security and retirement. I understand that it is my responsibility to report to _____ at the start of any income within 10 days of its beginnings. IF YOU HAVE NO INCOME PLEASE TELL US HOW YOUR HOUSEHOLD BILLS ARE PAID. IF ANOTHER PERSON PAYS THE BILLS, PLEASE PROVIDE A SIGNED LETTER OF SUPPORT.

By signing this document I am agreeing that all the information is true and accurate to the best of my knowledge.

Signature _____ Date _____

