

[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Hospital/Clinic Name]
[Billing Department Address]
[City, State, Zip Code]

RE: Financial Assistance / Charity Care Application

Patient Name: [Patient Name]
Account Number: [Your Account Number]
Total Balance: [Total Amount Due]

To the Billing Department,

I am writing to formally request a full waiver of my medical bills under your hospital's Charity Care and Financial Assistance program. I am currently experiencing severe financial hardship and do not have the resources to pay the outstanding balance.

My current financial situation is as follows:

- Current Employment Status: [Employed/Unemployed/Disabled]
- Monthly Household Income: [Amount]
- Number of Household Dependents: [Number]
- Reason for Hardship: [Briefly describe, e.g., job loss, medical disability, or low income]

Enclosed with this letter, please find the required documentation to support my application, including:

- Copies of my most recent pay stubs or proof of unemployment.
- My most recent federal tax return.
- Bank statements from the last three months.
- A list of monthly essential expenses (rent, utilities, food).

I request that you review my application for a 100% forgiveness of this debt based on my income falling below the Federal Poverty Guidelines. While this application is being processed, I ask that you place my account on hold and refrain from sending it to any third-party collection agencies.

Thank you for your time and for providing this essential service to the community. I look forward to receiving your written decision regarding my eligibility.

Sincerely,

[Your Signature]

[Your Printed Name]