[Hospital or Clinic Name]
[Billing Department]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Patient Name]
[Address]
[City, State, Zip Code]

Re: Financial Hardship Application Approval
Account Number: [Account Number]

Dear [Patient Name],

We are writing to inform you that your application for financial assistance regarding your outstanding medical balance has been reviewed and approved.

Based on the financial information provided, we have determined that you qualify for a [Percentage, e.g., 100%] discount on the following services:

- Date of Service: [Date]
- Service Description: [Service Name]
- Original Balance: $[Amount]
- **New Balance Due: $[Amount]**

This approval applies only to the specific account number and dates of service listed above. Please note that this assistance covers hospital/clinic charges and may not include independent physician or laboratory fees.

If there is a remaining balance due, please submit payment by [Date] or contact our office to set up a monthly payment plan. If your balance is now $0.00, no further action is required at this time.

If you have any questions, please contact the Billing Department at [Phone Number] between the hours of [Hours of Operation].

Sincerely,

[Name/Signature]
[Title]
[Department Name]