[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Name of Financial Assistance Department/Provider]
[Name of Institution]
[Address]
[City, State, Zip Code]

RE: Financial Hardship Assistance Application for [Your Name/Patient Name]
Account Number: [Your Account Number]

To Whom It May Concern,

I am writing to formally request financial assistance or a payment reduction regarding my medical bills. I am currently receiving ongoing treatment for a chronic medical condition, [Name of Condition], which requires continuous care, medication, and monitoring.

Due to the long-term nature of this illness, I am experiencing significant financial hardship. My ability to pay the full balance of [Total Amount Owed] is limited by the following circumstances:

- [Reason 1: e.g., Reduced income or loss of employment]
- [Reason 2: e.g., High cost of monthly prescriptions and co-pays]
- [Reason 3: e.g., Essential living expenses exceeding monthly income]

I have attached documentation to support this request, including [List attachments: e.g., recent pay stubs, tax returns, or bank statements].

I am committed to fulfilling my financial obligations to the best of my ability. I am requesting that you consider one of the following options:

- A reduction in the total balance owed.
- A waiver of the current outstanding fees.
- An interest-free monthly payment plan of $[Amount You Can Afford] per month.

Please let me know if there are specific financial assistance forms I need to complete or if additional information is required. Thank you for your time and for considering my request during this difficult time.

Sincerely,

[Your Signature]

[Your Printed Name]