**Grace Health-Consideration of Hardship Application**

**Date:** _____

| **Patient Name:** | **Date of Birth:** |
|---|---|
| **Address:** | |
| | |
| **Date of Service:** | **Encounter #:** |

Dear Sirs,

I am requesting a Consideration of Hardship for the following reason (please check all that apply):

a. Loss of home/residence
b. Loss of employment
c. Loss of unemployment compensation
d. Recent separation /divorce
e. Loss of immediate family member
f. Monthly prescription costs

Please **describe why** you need this hardship consideration (use the back of this page if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Mail completed copy of this form to:
Grace Health
1019 Cumberland Falls Hwy, Suite B201
Corbin, KY 40701
Attention: Billing