Financial Hardship Form

S&G Labs Hawaii, LLC is committed to treating all patients equitably, with dignity and respect regardless of the patient's health care insurance benefits or financial resources. S&G Labs is available to help patients address any financial responsibilities they may have to pay for our laboratory services in a way that is fair and sensitive to their circumstances. Consistent with Hawaii and federal law, S&G Labs has instituted this Patient Assistance Program for patients who are unable to pay the entire amount of their bill due to financial hardship, as determined by Federal Poverty Guidelines.

Patients may apply for a Financial Hardship Discount by completing and signing this Application Form. Patients are encouraged to apply for a Financial Hardship Discount prior to making any payment to their account. As part of Patient Assistance Program, S&G Labs will reevaluate all eligible patients annually. S&G Labs reserves the right to request that any eligible patient submit any supporting documentation for proof of eligibility and/or continuing eligibility. The amount of Financial Hardship Discount will be determined based on the Hawaii Federal Poverty Guidelines – for 2019, the Financial Hardship Discount will be calculated as follows:

Annual Household Income

Persons in Household	100% of Federal Poverty Guidelines	200% of Federal Poverty Guidelines
1	$14,380	$28,760
2	$19,460	$38,920
3	$24,540	$49,080
4	$29,620	$59,240
For each additional person	$5,080	$10,160
Financial Hardship Discount	**75%**	**50%**

To be eligible for a Financial Hardship Discount:

- You must be uninsured or underinsured (co-pays) for the S&G Labs Hawaii testing services.
- S&G Labs Hawaii must have received a valid order for S&G Labs Hawaii testing services from your treating healthcare provider confirming the testing services are medically necessary for your treatment.
- Your annual household income must be at or below 200% of current Hawaii Federal Poverty Guidelines (above).

You must complete and sign this Application with the following information:

Patient Name _____

Home Address _____

Phone _____

Employer (if any) Address _____

Your S&G statement number _____

Your Date(s) of lab service _____

Total Household Gross Income $_____

Number of persons in Household _____

I HEREBY AFFIRM THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AGREE THAT I WILL NOTIFY S&G Labs Hawaii OF ANY MATERIAL CHANGE IN MY FINANCIAL CIRCUMSTANCES, WHICH INCLUDES A CHANGE HOUSEHOLD INCOME OR INSURANCE. I HEREBY ATTEST THAT I AM NEITHER RELATED TO, NOR EMPLOYED BY, THE PHYSICIAN WHO ORDERED THE TESTING.

Patient Signature _____

Date _____

S&G Labs HAWAII, LLC
HAWAII BASED & OWNED

S&G Labs Hawaii, LLC

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