# FINANCIAL HARDSHIP INFORMATION FORM

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## PERSONAL INFORMATION

**FULL NAME** : _____

**ADDRESS** : _____

**ZIP CODE** : _____

**CITY** : _____

**STATE** : _____

**OCCUPATION** : _____

**PRESCRIBER** : _____

**DATE OF BIRTH**

Month 12 Day

Year

**SOCIAL SECURITY NUMBER**

**MEDICARE NUMBER**

ALL INFORMATION WILL BE KEPT CONFIDENTIAL BY REALO SPECIALTY CARE PHARMACY.

## FINANCIAL INFORMATION

**MONTHLY INCOME** : _____

**SOURCE(S)** : _____

_____

**HOUSEHOLD SIZE** : _____

**DO YOU OWN OR RENT YOUR HOME?**

OWN ☐ RENT ☐

**MONTHLY PAYMENT** : _____

**DO YOU OWN A VEHICLE?**

YES ☐ NO ☐

**MONTHLY PAYMENT** : _____

**DO YOU HAVE ANY INSURANCE COVERAGE?**

YES ☐ NO ☐

**IF YES, LIST** : _____

_____

**PLEASE LIST YOUR USUAL MONTHLY EXPENSES.**

**UTILITIES** : _____

**FOOD** : _____

**CLOTHING** : _____

**MEDICAL** : _____

**TRANSPORTATION** : _____

**OTHER (SPECIFY)** : _____

**PLEASE LIST AMOUNT OF ALL DEBTS THAT YOU OWE IN EXCESS OF $100**

_____

**ARE YOU ABLE TO PAY FOR ANY PORTION OF YOUR PRESCRIPTION COSTS THAT ARE INCURRED THROUGH REALO SPECIALTY CARE PHARMACY?**

YES ☐ NO ☐

**IF YES, WHAT AMOUNT CAN YOU PAY:** _____

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED ON THIS FINANCIAL HARDSHIP INFORMATION FORM IS COMPLETE, TRUE AND ACCURATE.

**PATIENT'S NAME (PLEASE PRINT)** : _____

**PATIENT'S SIGNATURE** : _____

**DATE SIGNED:**

Form Revised: 05/24/2022