Hill-Rom
Enhancing Outcomes for Patients and Their Caregivers.™

Advanced Respiratory, Inc. A Hill-Rom Company
1020 West County Road F
Saint Paul, MN 55126-9864
Telephone (800) 426-4224 ▪ Confidential Fax (888) 295-1860

PATIENT APPLICATION for FINANCIAL OBLIGATION WAIVER

This application is required for persons interested in receiving assistance from Advanced Respiratory, Inc., A Hill-Rom Company. Please complete ALL sections of this form and include all required documentation.

A Financial Representative will contact you promptly once your application has been received and a determination has been made regarding assistance to be offered. If you have any questions or concerns while completing this application, please feel free to contact us at the toll-free number listed above.

PATIENT INFORMATION

Name ______________________ Account Number ______________________
If not known, leave blank

Address ______________________ Date of Birth ______________________

City ______________________

State __________ Zip __________ Telephone Number ______________________

Number of Persons in Household __________ Number of Persons with Chronic Conditions __________

Are you a Citizen of the U.S.? Yes ☐ No ☐ If No, please submit photocopy of Legal Resident Card.

PRODUCT INFORMATION

Please check the box for which Product Type applies

☐ The Vest® Airway Clearance System ☐ VitalCough® System ☐ Monarch ™ System
Co-pay, co Ins, and deductible only

Serial Number of Device __________ Serial Number of Device __________

Do you currently have a Device? Yes ☐ No ☐

Income

*Monthly Household Income**	*Primary Applicant*	*Secondary Applicant*
Gross Wages, Salaries, and Tips	$	$
Social Security / Disability	$	$
Pension or Other Retirement Benefits	$	$
State or Other Assistance (i.e. Food Stamps)	$	$
Investments or Dividends	$	$
Unemployment Compensation	$	$
Alimony / Child Support	$	$
Other Income (Indicate Source)	$	$
Total		(B)

****Proof of income is required***

RELEASE AND CERTIFICATION

I am submitting the information above for the purpose of obtaining financial assistance from Advanced Respiratory, Inc. I certify that the information provided is true and correct to the best of my knowledge. I understand that the information is in strict confidence and will be used only by Advanced Respiratory, Inc. to ascertain my ability to pay for services provided by Advanced Respiratory, Inc.

I understand that this application is subject to the guidelines of The Patient Assistance Program and that eligibility will be determined by the program guidelines and criteria.

______________________ ______________________
Signature of Applicant Date

Internal Use Only

Recommendation -

_____________________ Initial Review

_____________________ Final Review __________%