COMPASSION HEALTH TOLEDO REQUEST FOR WAIVER OF CHARGES

Name: ____________________________________Date of Birth______________________________

Date:____

I would like to request that my charges be waived for my visit(s) on date (s)

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The following circumstances have made it impossible for me to pay my bills at Compassion Health Toledo

- ☐ Eviction or facing eviction; sudden homelessness; other reason for loss of shelter;
- ☐ High level of damage and/or loss of home/apartment to fire, natural disaster, or other destruction;
- ☐ Heating, electric, water, or other key utility shut-off notice;
- ☐ Experiencing domestic violence;
- ☐ Multiple chronic illnesses, high medical costs and/or medical debt due to disease/illness;
- ☐ Sudden loss of job/unemployment;
- ☐ Filed bankruptcy;
- ☐ Other circumstances which cause the patient to be unable to pay their share of fees owed for services provided

If possible, I am attaching documentation that demonstrates the above problems. I will notify Compassion Health Toledo at my next visit if these circumstances change.

Thank you for your consideration,

Signature____

1638 Broadway St
Toledo, Ohio 43609
567-661-0565