**FINANCIAL HARDSHIP CERTIFICATION**

I, _____ have requested Financial Hardship relief for medical services provided by _____. I hereby stipulate that my family income is within the federal guidelines identified below:

| FAMILY SIZED | ANNUAL INCOME |
|---|---|
| 1 | $ 8,980.00 |
| 2 | $ 12,120.00 |
| 3 | $ 15,260.00 |
| 4 | $ 18,400.00 |
| 5 | $ 21,540.00 |
| 6 | $ 24,680.00 |
| 7 | $ 27,820.00 |
| 8 | $ 30,.960.00 |
| EACH ADDITIONAL PERSON | $ 3,140.00 |

Signature: _____

Date: _____