HONORHEALTH™

Rehabilitation Hospital

In affiliation with Select Medical

# FINANCIAL ASSISTANCE DISCLOSURE

- **Thank you for completing the information below. In addition to the completed form, we will need a copy of last year's tax return, W2's, 2 most recent pay stubs, 2 current months of any/all bank statements and any other income/asset verifications, including 2 months of all investment accounts. Please return your application and supporting documentation as soon as possible to ensure timely processing.**
- **Financial assistance applies to facility charges only. Discounts do not apply to third parties involved in a patient's care. Examples of third parties involved in patient's care include but are not limited to Emergency Room Physicians, Pathologists, Radiologists, and Anesthesiologists.**

| PATIENT INFORMATION | | |
|---|---|---|
| **Patient Name** | **Account #** | **Estimate/Balance** |
| **SS#** | **Date of Birth** | |
| **Relationship to Guarantor** | | |

| GUARANTOR INFORMATION | | |
|---|---|---|
| **Name** | | |
| **SS#** | | **Birthdate** |
| **Address** | | **Phone** |
| **City** | **State** | **Zip** |
| **Employer** | **Length of Employment** | **Est Gross Income** |
| **Income from Other Sources (eg, child support, alimony, retirement)** | | |

| SPOUSE INFORMATION | | |
|---|---|---|
| **Name** | | |
| **SS#** | | **Birthdate** |
| **Address** | | **Phone** |
| **City** | **State** | **Zip** |
| **Employer** | **Length of Employment** | **Est Gross Income** |
| **Income from Other Sources (eg, child support, alimony, retirement)** | | |

| DEPENDENT INFORMATION | | |
|---|---|---|
| **Name (Last, First, Middle Initial)** | **Relationship** | **Date of Birth** |
| | | |

Mail Application to:
HonorHealth Rehabilitation Hospital
Admitting Department
8850 E. Pima Center Parkway
Scottsdale AZ 85258
Phone:480-800-3905
Fax:717-412-9480

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|---|---|---|
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| BANK INFORMATION | | |
|---|---|---|
| **Bank Name** | **Checking Balance** | **Savings Balance** |
| **Bank/Credit Union Name** | **Checking Balance** | **Savings Balance** |

| EXPENSES | | |
|---|---|---|
| **Mortgage/Rent** | **Balance** | **Monthly Payment** |
| **Home Equity Value** | | |
| **Car (Make, Year, Model)** | | |
| **Food/Household Supplies** | | |
| **Gasoline/Transportation** | | |
| **Utilities** | | |
| **Telephone** | | |
| **Child Care** | | |
| **Insurance** | | |
| **Student Loans** | | |
| **Child/Spousal Support** | | |
| **Medical Expenses** | | |
| **Credit Cards (Specify Each)** | | |
| | | |

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|---|---|---|
| | | |
| **TOTAL MONTHLY EXPENSES** | | |

**I certify that the information provided in this financial disclosure worksheet and on any attachments is accurate and complete to the best of my knowledge. By signing below, I authorize HonorHealth Rehabilitation Hospital to verify any credit and employment history, including running a credit report as necessary to assess financial need. I further understand that I must update this information if requested and/or if my financial situation changes.**

**Applicant Signature** **Date**

**CEO Signature** **Date**

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