



**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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<b>BANK INFORMATION</b>		
<b>Bank Name</b>	<b>Checking Balance</b>	<b>Savings Balance</b>
<b>Bank/Credit Union Name</b>	<b>Checking Balance</b>	<b>Savings Balance</b>

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

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<b>TOTAL MONTHLY EXPENSES</b>		

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

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