REGENCY HOSPITAL COMPANY

Financial Assistance Application Form

SECTION ONE: PATIENT INFORMATION
Print your full name, your address at the time you received medical service and other information noted in this section.

Account Number ______________________ Date(s) of Service ______________________

Patient Name: ____
LAST FIRST MIDDLE INITIAL

Address: ______________________ City: ______________ County: ______________
NUMBER AND STREET

State of Residence: ____________ Zip Code: ____________ Date of Birth: ____/____/____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Primary Phone Number: (__________) ______________ ☐ Home ☐ Mobile ☐ Work ☐ Other ______________

Email Address: ______________________________________

Health insurance at time of date of service: ☐ No Insurance ☐ Medicare ☐ Medicaid ☐ Other ______________

SECTION TWO: FAMILY INCOME AND ASSETS
Provide income for yourself, your spouse and all other family members (if applicable).

Income Source	Total for 3 Months Prior to Service	Total for 12 Months Prior to Service
Wages/Self Employment	$	$
Social Security	$	$
Pension, Dividends, Interest, Rental Income	$	$
Unemployment, Workers' Compensation	$	$
Child Support (only if the patient is the intended recipient)	$	$
Other	$	$

Total Net Assets (Assets - Debt) as if the Date of Application: $______________________

SECTION THREE: FAMILY INFORMATION AND INCOME
List all family members in your household and their date of birth.

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of HCAP, family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Name of family members, including patient | Date of Birth | Relationship to Patient

1. Patient: ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

By my signing below, I certify that everything I have stated on this application and on any attachments is true.

Responsible Party Signature: x ______________________________ Date: ____________

Return your completed application to: **Regency Hospital of Cleveland West**
225 Grandview Avenue, Camp Hill, PA 17011 (888) 868-1103
Email: IPCS@selectmedical.com Fax: (717) 980-2509