Select Medical
Financial Hardship Disclosure Form

Patient Account Number

Patient Name (Last, First, MI) Social Security Number

Patient Address City State Zip Code

Birth Date (Month/Date/Year) Telephone Number

Marital Status: O Married O Single O Widowed O Separated O Divorced

Employed O Yes O No
Patient's Employer _____
Telephone # _____

Spouse's Name _____
Employed O Yes O No
Spouse's Employer _____
Telephone # _____

Other Select Medical accounts for your household with an unpaid balance (Please list patient's NAME, DOB and FACILITY NAME)

If unemployed, please include the previous employer's name and telephone number*

A. *Income:* Please provide the income for each of the following persons in your household.

Patient
Monthly Gross Income **$** _____
Additional Income **$** _____

Spouse
Monthly Gross Income **$** _____
Additional Income **$** _____

Total Household Income$ _____

Please complete only if patient is a minor (if not leave blank)

Patient's Father
Monthly Gross Income **$** _____
Additional Income **$** _____

Patient's Mother
Monthly Gross Income **$** _____
Additional Income **$** _____

Total Household Income$ _____

B. *Income Verification:* Please provide verification ***(send only copies, no original documentation)*** for all sources of household income (acceptable documentation listed below).

Check attached documents:

o Paycheck Remittance
o IRS Form W-2
o Bank Statements
o Employer Verification
o Tax Return
o Social Security
o Money Market/Investment
o Certificate of Deposit/Savings
o Workers Compensation
o Unemployment Compensation
o Government Assistance (Food Stamps,CDIC,Medicaid,TANF)
o Other (describe below)

If you are unable to provide one of the sources of income documentation listed above, please explain why it's not available: _____

C. *Family Members:* Please provide the total number of people in the patient's household.
(This number should only include the patient, patient's spouse, and the patient's dependents)

D. *Assets and Other Resources:*

Do you have any assets or other resources available to you? O Yes O No If Yes, current amount available: $_____

(Examples include savings accounts, trusts, stocks, bonds, mutual funds, etc.

Do you have medical insurance? O Yes O No If Yes, please list provider name: _____

Do you have a Health Savings Account or Flexible Spending Account? O Yes O No
If Yes, current amount available:$_____

Income documentation must be included to make a determination. Please furnish a copy of the 3 most recent paystubs for all household income reported and copy of most recent income tax return. If not required to file a federal tax return, Medicare patients may submit a copy of their social security letter for the year showing the gross monthly amount received. Please note that additional information may be requested if needed to assist in making a determination. Net asset documentation must be included to make a determination. Please furnish copy of most recent month's bank statements and loan statements.

I the undersigned, certify that the above information is true and accurate.

_____ _____

SIGNATURE Date

_____

WITNESS/TITLE

Amount of Waiver Based on Financial Hardship [To be completed by CBO] _____ %

_____ _____ _____

CBO Supervisor Approval Signature Printed Name Date

_____ _____ _____

Patient Account Number Hospital Database # and Name Outstanding Balance