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 East**
225 Grandview Avenue, Camp Hill, PA 17011 (888) 868-1103
Email: IPCS@selectmedical.com Fax: (717) 980-2509