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:$______________

Last Reviewed Date: 2/11/2021

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