Everest REHABILITATION HOSPITALS, LLC.

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION			
PATIENT NAME:	AGE:	PHONE #:	MRN:
HOME ADDRESS: ☐ Rent ☐ Own			
SSN	Marital Status	Discharge Diagnosis	
Name & Address of employer:	Employer Phone#	How long employed?	
Position/Title:		Supervisor's Name:	
If unemployed, last date & place of employment		Position/Title	

RESPONSIBLE PARTY INFORMATION			
NAME:	Relationship to patient	Age	Telephone No.
Street address, if different from patient:			
SSN	Marital Status	Family Size	Names & Ages
Name & Address of Employer	How long employed?	Employer Telephone No.	
Position/Title:		Supervisor's Name	
If unemployed, last date & place of employment		Position/Title	
Name of nearest relative:		Relationship	
Address		Telephone No.	

SPOUSE INFORMATION			
Name	Age	SSN	Name of employer
Name & Address of Employer	How long employed?	Employer Telephone No.	
Position/Title:		Supervisor's Name	
If unemployed, last date & place of employment		Position/Title	

MONTHLY INCOME				ASSETS	
ITEM	☐ Patient ☐ Spouse ☐ Father ☐ Mother	☐ Patient ☐ Spouse ☐ Father ☐ Mother	☐ Patient ☐ Spouse ☐ Father ☐ Mother	Checking Account(s)-bank & account number:	Balance:
Base Income					
Overtime				Savings Account(s)-bank balance & Account No.	
Social Security					
Interest/Dividends				Other Accounts(s) – bank balance & Account No.	
Rental Income					

Alimony/Child				Life Insurance – company & Value
Unemployment				
State Assistance				Stocks, Bonds & Mutual Funds Value
Food Stamps				
Pension				Automobiles Make & Value
Disability				
Worker's Comp				Real Estate (list & describe) Present Value:
Other				Other Assets (personal) Value
TOTAL				**TOTAL ASSETS**

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PLEASE COMPLETE THE INFORMATION AS THOROUGHLY AS POSSIBLE SO THAT AN ACCURATE ASSESSMENT OF YOUR CURRENT FIANCIAL SITUATION CAN BE DETERMINED. ALONG WITH THE FINANCIAL STATEMENT, AT LEAST TWO OF THE FOLLOWING ITEMS ARE REQURIED FOR REVIEW. PLEAS PROVIDE THE FOLLOWING:

1. **MOST RECENTLY FILED FEDERAL AND STATE INCOME TAX**
2. **LAST THREE MONTHS OF BANK ACCOUNT STATEMENTS (CHECKING & SAVINGS)**
3. **VERIFICATION OF INCOME (PAYCHECK STUBS, UNEMPLOYMENT CHECK, SOCIAL SECURITY CHECKS, ETC.)**

MONTHLY EXPENSES		OTHER EXPENSES	MONTHLY PAYMENT	BALANCE	PAYMENT CURRENT?
Item	**Monthly Payment**	**Charge Accounts**			
Rent					☐ YES ☐ NO
Mortgage					☐ YES ☐ NO
Electricity					☐ YES ☐ NO
Gas/Propane					☐ YES ☐ NO
Water		Personal loan			☐ YES ☐ NO
Refuse					☐ YES ☐ NO
Telephone					☐ YES ☐ NO
Cable TV					☐ YES ☐ NO
Food		Cell Phone			☐ YES ☐ NO
Clothing					☐ YES ☐ NO
Medicine					☐ YES ☐ NO
Childcare					☐ YES ☐ NO
Transportation		Auto Loan			☐ YES ☐ NO
Alimony/Child Support					☐ YES ☐ NO
Auto					☐ YES ☐ NO
Life Insurance					
Health					
Personal					
Real Estate		Misc.			
Sub Total					

TOTALS	TOTAL MONTHLY PAYMENTS	TOTAL BALANCE	

SUMMARY	
Total Monthly Income	
Total Monthly Expenses	
Discretionary Income	
Monthly Payment Arrangements	

OTHER EXPENSES

Will the patient be unable to work or go to school due to physical impairment?

☐ YES ☐ NO

If yes, what is the disabling condition or diagnosis?

How long will the patient be disabled? (Please attach physician statement)
COMMENTS:
PATIENT AGREEMENT
The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The original or a copy of this application will be retained by the creditor, even if financial assistance is not granted. The undersigned also agrees to allow this facility to contact any or all of the above references for credit verification, including credit bureaus. Patient Signature_____ Responsible Party / Spouse Signature: _____ Facility Representative/Dept.: _____ Date: _____

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Date:	Account #:
Patient Name:	Dates of Service:

_____ Your application for financial assistance has been approved in the amount of; _____%. This allowance will be applied to the hospital charges remaining after all applicable insurance benefits have been paid. This allowance does not apply to your physician bill or non-covered items such as take-home items, etc. The balance remaining, after financial assistance has been applied, must be paid by cash personal check or money order. Please contact the Patient Accounts Department regarding your choice of payment options.

Your current balance after financial assistance is $_____

_____ Your application for financial assistance has been denied. Your level of income is higher than the standard level used to compute our financial assistance allowance.

Sincerely,