PATIENT FINANCIAL ASSISTANCE PROGRAM

APPLICATION

Select Specialty Hospital - Tucson recognizes that certain patients may require financial assistance in paying for healthcare services. The Patient Financial Assistance Program has been designed by the hospital in response to the needs of these patients.

Attached is the Patient Financial Assistance Application for you to complete and return to us by the date noted below. The information requested on the form will assist us in determining if you qualify for assistance. Please fill out the form as completely as possible and return with copies of the items that are checked below.

- ☐ **Most current W-2s and tax forms**
- ☐ **Last (3) paycheck stubs from employment**
- ☐ **Social Security Award Letter for current year**
- ☐ **Unemployment Compensation Benefit Letter**
- ☐ **Copy of Checking/Savings Account Statement(s)**
- ☐ **Rent Receipt/Lease/Mortgage Statement**
- ☐ **Room and Board/Support Letter**
- ☐ **Utility Bills**
- ☐ **Divorce Decree**

An incomplete application will be denied until it is fully completed.

Please submit application and support to:

Select Specialty Hospital – Tucson

225 Grandview Avenue, Camp Hill, PA 17011

Email: IPCS@selectmedical.com or Fax (717) 980-2509.

If you have any questions regarding the financial application or documents needed, please contact Central Business Office at (888)868-1103.

Select Specialty Hospital – Tucson CBO

Enc: Application

Select SPECIALTY HOSPITAL
A Critical Illness Recovery Hospital

PATIENT FINANCIAL ASSISTANCE PROGRAM

APPLICATION

PATIENT'S NAME			**SEX**	**PATIENT ACCOUNT NUMBER**		
GUARANTOR'S FIRST NAME	**MI**	**LAST NAME**		**SEX**	**DOB**	**SOCIAL SECURITY#**
ADDRESS OR PO BOX	**CITY**	**STATE**		**ZIP**		**PHONE**
SPOUSE'S FIRST NAME	**MI**	**LAST NAME**		**SEX**	**DOB**	**SOCIAL SECURITY#**
ADDRESS OR PO BOX	**CITY**	**STATE**		**ZIP**		**PHONE**
# IN HOUSEHOLD				**PATIENT LIVES IN HOUSEHOLD**		**YES ☐ NO ☐**
# OF CHILDREN UNDER 18 IN THE HOUSE HOLD				**# OF DEPENDENT CHILDREN OVER 18**		
# OF DEPENDENT CHILDREN OVER 18 THAT ARE FULL-TIME STUDENTS				**# OF DEPENDENT CHILDREN THAT ARE DISABLED**		
HOME	**OWN ☐**	**RENT ☐**	**HOW LONG AT PRESENT ADDRESS**			

MONTHLY INCOME SOURCES	**SPOUSE #1**	**SPOUSE #2**	**CHILDREN**	**TOTAL**
Employment				
Social Security				
Industrial Comp				
Unemployment				
Pension/Retirement/Annuities				
ADC,GA, Food Stamps				
Other (rental income, child support, spousal, etc.)				
TOTAL GROSS INCOME				

MONTHLY EXPENSES

HOME (RENT/MORTGAGE)	**CAR**	**CAR**
ELECTRIC BILL	**GAS BILL**	**WATER BILL**
PHONE BILL	**TRASH BILL**	**CABLE BILL**
CELL PHONE BILL	**GROCERY**	**OTHER**
CHECKING YES ☐ NO ☐	**$ TOTAL AMOUNT**	**BANK NAME**
SAVING YES ☐ NO ☐	**$ TOTAL AMOUNT**	**BANK NAME**

I CERTIFY THAT THE INFORMATION GIVEN HEREON IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT DELIBERATE FALSIFICATION CAN LEAD TO DENIAL OF CONSIDERATION. I HEREBY AUTHORIZE THE HOSPITAL TO MAKE ANY NECESSARY INQUIRIES TO VERIFY THE INFORMATION PROVIDED AND TO OBTAIN ANY ADDITIONAL INFORMATION REQUIRED BY FACILITY.

- RELATIONSHIP OF HOUSEHOLD MEMBERS: Divorce Decree or Copy of Death Certificate
- ASSETS: Bank and credit union statements for the last three (3) months
- Most current W-2's and tax forms
- INCOME FOR ALL HOUSEHOLD MEMBERS: Last (3) paycheck stubs/employer's statement listing gross wages, Social Security Award Letter for current year, or Unemployment Compensation Benefit Letter