

Financial Assistance Application Form

| Email Address: | SECTION ONE: PATIENT INFORMATION Print your full name, your address at t | | ce and other information | noted in this section. | |
|--|---|---|----------------------------------|--|--|
| Address: | Account Number | Date(s) of Service | | | |
| Address: | Patient Name: | | | | |
| State of Residence: | LAST | | FIRST | MIDDLE INITIAL | |
| Primary Phone Number: | Address: | TT TT | City: | County: | |
| Health insurance at time of date of service. Q No Insurance Q Medicare Q Medicare Q Medicare Q 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 S S Scial Security S S Pension, Dividends, Interest, Rental Income S S Unemployment, Workers' Compensation S S Child Support (only if the patient is the intended recipient) S S Child Support (only if the patient is the intended recipient) S S 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 PCAP, family is defined as the patient, the patient's spouse, and all of the patient's shifter under 18 (natural or adoptive) who live in the patient's home. If the patient's higher under 18 (natural or adoptive) who live in the patient's home. Beautiful to the special shifter under 18 (natural or adoptive) who live in the patient's home. Beautiful to the special shifter under 18 (natural or adoptive) who live in the patient's home. Beautiful to the special shifter under 18 (natural or adoptive) who live in the patient's home. Beautiful to the special shifter under 18 (natural or adoptive) who live in the patient's home. Beautiful to the special shifter under 18 (natural or adoptive) who live in the patient's home. Beautiful to the special shifter under 18 (natural or adoptive) who live in the patient's home. Beautiful to the special shifter under 18 (natural or adoptive) who live in the patient's home. Beautiful to the special shifter under 18 (natural or adoptive) who live in the patient's home. Beautiful to the special shifter the special s | State of Residence: | _ Zip Code: | Date of Birth:/ | / Marital Status: q Single q Married q Divorced | |
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| Social Security Social Security S Pension, Dividends, Interest, Rental Income Unemployment, Workers' Compensation S Unemployment, Workers' Compensation S Child Support (only if the patient is the intended recipient) Other S 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 soute and on 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 Patient: Date of Birth Relationship to Patient Patient: Patient: President: S S S S S S S S S S S S S | | | to Service | Total for 12 Months Prior to Service | |
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| 1. Patient: | Please provide the following information for a spouse, and all of the patient's children under 18 | all of the people in your immediate family B (natural or adoptive) who live in the patient | 's home. If the patient is under | , , , | |
| 2 | Name of family members, including patient | | Date of Birth | Relationship to Patient | |
| 3 | 1. Patient: | | | | |
| 4 | 2 | | | | |
| 5 | 3 | | | | |
| 6 | 4 | | | | |
| By my signing below, I certify that everything I have stated on this application and on any attachments is true. | 5 | | | | |
| | 6 | | | | |
| | Ry my signing helow I certify that everything I ha | ave stated on this application, and on any att | achments is true | | |
| | | and on any action and on any action | delinicity to state | Date | |

Return your completed application to: Select Specialty Hospital – Cleveland Fairhill 225 Grandview Avenue, Camp Hill, PA 17011 (888) 868-1103

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