ERNEST HEALTH, INC.

Applies to:
Central California Rehabilitation Hospital
Rehabilitation Hospital of Southern California
Sacramento Rehabilitation Hospital
Stockton Regional Rehabilitation Hospital

REQUEST FOR HARDSHIP ASSISTANCE

Attached is a Financial Disclosure Form that must be completed to determine if you will qualify for a Hardship Exception through the Charity Care or Discount Payment program. The Financial Disclosure Form must be filled out completely. If applying for Discounted Payment only, proof of income must be attached (either recent paystubs within the last six (6) months or prior year's tax return).

The Financial Disclosure will then be reviewed and a determination made. Depending on your financial status, you may receive a percentage discount of charges incurred or a 100% discount, known as Charity Care.

ERNEST HEALTH will file claims with all insurance, Medicare and Third-Party Liability. If you qualify for any State Funded Programs, please provide information regarding your application status.

The Financial Disclosure Form will only be in effect for the dates of service that are currently being rendered and will not cover services indefinitely.

Based upon future discussions with you regarding your financial situation, the hospital may determine that your financial situation has improved enough to remove the Hardship Exemption thereby requiring payment from you for the charges incurred.

THIS APPLICATION DOES NOT APPLY TO THE PHYSICIANS BILLING FOR THEIR PERSONAL SERVICES. YOU MUST CONTACT THOSE RESPECTIVE PHYSICIANS TO MAKE PAYMENT ARRANGEMENTS FOR THEIR BILLS.

Please indicate if you are applying for Charity Care or Discount Payment by checking the appropriate box below.

_____ Charity Care – If approved, this can provide up to a full write-off of all patient balances for the approved dates of service.

_____ Discount Payment – If approved, this can provide a reduced payment of all patient balances for the approved dates of service. If applying for Discount Payment, financial assistance may be less than what may be available under Charity Care.

By signing below and submitting the Financial Disclosure Form you agree to the best of your knowledge that the information contained therein is accurate.

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_____ _____

Signature of Applicant Date

Approved: _____ Yes _____ No

Approved or Non-Approved by:

_____ _____

(CFO and/or CEO) Date

Amount Approved: _____ Balance Due (If any):_____

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Financial Disclosure Form

Patient Name	Address, City, State, Zip	How long residing at this address?
Responsible Party	Address, City, State, Zip	How long residing at this address?

Monthly Obligations:

Mortgage/ Rent: $ _____

1st Mortgage Holder: _____ 2nd Mortgage Holder: _____

Condo Fee: $_____

Avg. Electric/Gas: $_____ Avg. Telephone: $_____ Avg. Water: $_____

Insurance Costs: $_____ Car Payment: $_____ Avg. Food Cost: $_____

Credit Cards (Itemize by Type):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Child Support: $_____ Alimony: $_____

Other Medical/Dental: $_____ Other Expenses: $_____

Total Expenses: $_____

Monthly Income:

Your Employer: _____ Monthly Income (Before Taxes): $_____

Spouse's Employer: _____ Monthly Income (Before Taxes): $_____

Attach copies of pay stubs within the last six (6) months or prior year's income tax return, including schedules if applicable. You may submit other forms of proof of income if you wish, but additional proof of income is not required. If you do not have proof of income or no income, please attached an additional page with an explanation.

Monthly Child Support/Alimony Income: $_____ Other Income: $_____

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Total Monthly Income: $_____

Amount patient feels they can pay for services each month $_____

The above information is privileged and confidential.

_____ _____

Date Patient/Responsible Party Signature

Patient's estimated balance after insurance: $_____

Account is approved for: $_____

Comments: _____

Patient Account Manager: _____ Date: _____

Business Office Manager: _____ Date: _____

CFO/CEO: _____ Date: _____