Financial Assistance Application Form

Please use this form to apply for charity care (no cost) or discounted care at Select Specialty Hospital- San Diego. If you need any help in applying, please contact our admissions department or call Customer Service at (888) 868-1103.

SECTION ONE: PATIENT INFORMATION

Print your full name, your address at the time you received medical service and other information noted in this section.

Account Number _____ Date(s) of Service _____

Patient Name: _____

Last First Middle Initial

Street Address: _____ City: _____ County: _____

State of Residence: _____ Zip Code: _____ Date of Birth: _____

Marital Status:

○ Single ○ Married ○ Divorced

Primary Phone Number: ( )_____

○ Home ○ Work ○ Mobile ○ Other:_____

Email Address: _____

Health insurance at time of date of service:

○ No Insurance ○ Medicare ○ Medicaid ○ Other:_____

Return your completed application to: **Select Specialty Hospital - San Diego**
225 Grandview Avenue, Camp Hill, PA 17011 (888) 868-1103
Email: IPCS@selectmedical.com Fax: (717) 980-2509

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SECTION TWO: FAMILY INCOME

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	$	$
Social Security	$	$
Pension, Dividends, Interest, Rental Income	$	$
Unemployment, Workers' Compensation	$	$
Child Support (only if the patient is the intended recipient)	$	$
Other	$	$

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 family. For persons 18 years of age and older, "family" means the patient's spouse, domestic partner (as defined in Section 297 of the Family Code), and dependent children under 21 years of age, or any age if disabled, whether living at home or not. For persons under 18 years of age or for a dependent child 18 to 20 years of age, "family" includes parents, caretaker relatives, and parents' or caretaker relatives' other dependent children under 21 years of age, or any age if disabled.

Name of family members, including patient | Date of Birth | Relationship to Patient

1. Patient: _____
2. _____
3. _____
4. _____
5. _____
6. _____

By my signing below, I certify that everything I have stated on this application and on any attachments is true.

Responsible Party Signature: x _____ Date: _____

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