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 to include either:

1. Recent paystubs within a six (6) month period before or after the patient is first billed, or in the case of pre-service, when the application is submitted; or
2. Recent tax returns which document a patient's income for the prior 12-months in which the patient was first billed, or in the case of pre-service, when the application was submitted.

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.

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.

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 either:

1. Recent paystubs within a six (6) month period before or after the patient is first billed, or in the case of pre-service, when the application is submitted; or
2. Recent tax returns which document a patient's income for the prior 12-months in which the patient was first billed, or in the case of pre-service, when the application was submitted.

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 attach an additional page with an explanation.

Monthly Child Support/Alimony Income: $____________ Other Income: $______________

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: ____________