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 Exemption through discount payment or charity care (free care). The Financial Disclosure Form must be filled out completely. If applying for discounted payment only, proof of income must be attached (either the prior two months of pay stubs or prior two years of tax returns).

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 and request for hardship is used as a last resource ONLY.

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.

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): $_____

(For Discount Payment Only: Attach copies of past two months of pay stubs or prior two years of income tax returns)

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

Total Monthly Income: $_____

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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: _____