Instructions - financial assistance application

Section A – patient and guarantor information

1. Patient Name: Clearly print on the blank line the first name, middle initial, and last name of the patient.
2. Date: Clearly print on the blank line the date of the application.
3. Guarantor: Clearly print on the blank line the first name, middle initial, and last name of the patient's parent, legal guardian or other responsible person ("guarantor").
4. Relationship: Clearly print on the blank line the relationship to the patient of the guarantor.
5. Address: Clearly print on the blank line the address where the patient lives including the city, state and zip.
6. Phone: Clearly print on the blank line the patient's phone number.
7. Patient's Employer: Clearly print on the blank line the name of the company for which the patient works.
8. Title: Clearly print on the blank line the job title of the patient.
9. Years Employed: Clearly print on the blank line the start date of employment.
10. Spouse's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient/guarantor's spouse.
11. Spouse's Phone: Clearly print on the blank line the patient's phone number.
12. Spouse's Employer: Clearly print on the blank line the name of the company for which your spouse works.
13. Title: Clearly print on the blank line the job title of your spouse.
14. Years Employed: Clearly print on the blank line the start date of employment of your spouse.
15. Length of Time at Current Residence: Clearly print on the blank line the dates you have lived at the address provided on the application.
16. Total number of Dependents: Clearly print on the blank line the number of dependents in your household, including yourself. Dependents are those that generally qualify as your dependent for federal income tax purposes.
17. Health Insurance Provider: Clearly print on the blank line the name of your health insurance carrier (including Medicare, Medicaid or other governmental coverage you may have).
18. Policy number: Clearly print on the blank line the policy or account number of your insurance policy.

Section B – assets

Total Household Income: Clearly print the assets of your household (yourself, your spouse, and dependents). You may attach additional sheets of paper if more space is needed. Provide the cash value as well as any loans or obligations you have on that asset

- If your household has assets that you do not see listed, please indicate that amount on the line for "Other" and provide a description.
- Assets include, but are not limited to savings and checking accounts, medical savings accounts, healthcare savings accounts, flexible spending accounts, trusts, retirement accounts, investment assets, other liquid assets, real estate (other than primary residence), benefits from charity organizations, pending or finalized litigation settlements, etc.
- Years Employed: Clearly print on the blank line the start date of employment.
- Spouse's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient/guarantor's spouse.
- Spouse's Phone: Clearly print on the blank line the patient's phone number.
- Spouse's Employer: Clearly print on the blank line the name of the company for which your spouse works.
- Title: Clearly print on the blank line the job title of your spouse.

- Years Employed: Clearly print on the blank line the start date of employment of your spouse.
- Length of Time at Current Residence: Clearly print on the blank line the dates you have lived at the address provided on the application.
- Total number of Dependents: Clearly print on the blank line the number of dependents in your household, including yourself. Dependents are those that generally qualify as your dependent for federal income tax purposes.
- Health Insurance Provider: Clearly print on the blank line the name of your health insurance carrier (including Medicare, Medicaid or other governmental coverage you may have).
- Policy number: Clearly print on the blank line the policy or account number of your insurance policy.

Section C – income

Total Household Income: Clearly print the income your household (yourself, your spouse, and dependents) receives from all sources. You may attach additional sheets of paper if more space is needed. Provide the gross amounts and the amounts received after taxes and other deductions.

- If your household receives income from a source that you do not see listed, please indicate that amount on the line for “Other” and provide a description.
- Sources of income include, but are not limited to wages, tips, social security payments, retirement benefits, unemployment, workers’ compensation, veteran benefits, public assistance, alimony, child support, pensions, insurance or annuity contracts, investment income, etc.

Section D – debts and obligations

Total Household Debts and Obligations: Clearly print the debts and obligations of your household (yourself, your spouse, and dependents). You may attach additional sheets of paper if more space is needed. Provide the total amount of the liability and the monthly payment amounts.

- If your household has debts or obligations that you do not see listed, please indicate that amount on the line for “Other” and provide a description.
- If your household has debts or obligations that are not paid by you every month, take the total amount due during the past 12 months, divide it by 12, and then indicate that amount on the application.
- Sources of debts and obligations include, but are not limited to real estate mortgages, household utility bills, telephone, food, automobile loans, charge and credit accounts, other loans, etc.

Section E – required documentation

The documents listed in this section are needed to help us determine if you qualify for financial assistance under our Financial Assistance Policy. If you do not have, or cannot produce the items listed, please include an explanation as to why. Please note that additional information or documentation may be requested by a Hospital representative when processing your application.

Section F – Certification

Patient/Guarantor’s Signature: Carefully read the acknowledgement statement in this section and then sign and date the application.

Mailing Instructions/Contact Information

Submit the completed Financial Assistance Application along with supporting documentation to the hospital’s address.

Further information about the Financial Assistance Policy or assistance with the application process are available from the hospital controller via the hospital phone number, in person at the hospital address or online at the website address. Certain foreign language translations of the Financial Assistance Policy, Plain Language Summary, Financial Assistance Application and Instructions are available upon request.

Encompass Health

PLEASE SEE INSTRUCTIONS FOR ADDITIONAL INFORMATION ON COMPLETING THE APPLICATION

Section A - Patient Information

Patient Name			Date
Guarantor (if other than Patient)		Relationship	
Address			Phone
Patient's Employer	Title		Years Employed
Spouse's Name			Spouse's Phone
Spouse's Employer	Title		Years Employed
Length of Time at Current Address		Total number of Dependents (including yourself)	
17. Health Insurance Provider	18. Policy Number		

Section B - Assets

	Description	Cash Value
Checking Account (List Bank name)		$
Savings Account (List Bank name)		$
Other Account (List Bank name)		$

Item	Description	Balance Owed	Cash Value
3. Home Ownership		$	$
4. Other Real Estate		$	$
5. Automobile(s) Make and Year		$	$
6. Permanent Life Insurance		$	$
7. Other (Explain)		$	$
8. Other (Explain)		$	$
	Totals	$	$

Section C - Income

1. Your Gross Salary	☐ per month ☐ per year	After taxes and deductions
2. Spouse's Gross salary	☐ per month ☐ per year	After taxes and deductions
3. Other Income	☐ per month ☐ per year	After taxes and deductions
4. Other Income	☐ per month ☐ per year	After taxes and deductions
Description of Other Income		After taxes and deductions

Verification is required - please attach copies to show proof of income

Section D - Debts and Obligations

Please List All Debts - Verification is Required

		Total Owed	Monthly Payment
1. Household ☐ Own ☐ Rent		$	$
2. Utilities Electric, Gas, Water, etc			$
3. Telephone			$
4. Food			$
5. Automobile(s)	Payments	$	$
	Insurances	$	$
6. Charge Account(s), Credit Card(s) (List):			
a)		$	$
b)		$	$
c)		$	$
d)		$	$
e)		$	$
f)		$	$
7. Loans a) Finance Company		$	$
b) Bank		$	$
c) Credit Union		$	$
8. Miscellaneous (explain)		$	$
a)		$	$
b)		$	$

9. Liens or Judgments: Do you have any judgments or liens outstanding? ☐ Yes ☐ No

Section E - Required Documentation

Please provide a copy of the most recent income tax return filed with the IRS and documents to support the amounts provided in Sections B, C, and D. This includes copies of the most recent paystubs, account statements, etc.

Section F - Certification

I certify that the information on this application is a true and complete statement of the facts according to my best knowledge and belief. I understand that falsification of or failure to provide complete information requested on this application or failure/refusal to complete it, may result in being denied an extended payment plan or may void any payment agreement already in effect.

Signed:_____ Date:_____

Encompass Health Internal Use Only:

Date Received: _____

Controller Review: _____ Date: _____
signature

Administrative Approval/Denial: _____ Date: _____
(circle one) *signature*