Financial assistance application and instructions

Encompass Health Rehabilitation Hospital, an affiliate of Martin Health
5850 SE Community Drive
Stuart, FL 34997
772.324.3500
ehc.rehab/MartinFA

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 spouse'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.

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Section B - 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 C - Essential Living Expenses

Clearly print the monthly payment amounts for Essential Living Expenses of your household (yourself, your spouse, and dependents). You may attach additional sheets of paper if more space is needed.

If your household has debts or obligations that you do not see listed, please provide that information in section C.6.

Section D - 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 E - 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 listed above at the top of these instructions, in person at the hospital address listed above or online at the website address listed above. Certain foreign language translations of the Financial Assistance Policy, Plain Language Summary, Financial Assistance Application and Instructions are available upon request.

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Rehabilitation Hospital
an affiliate of Martin Health

PLEASE SEE INSTRUCTIONS FOR ADDITIONAL INFORMATION ON COMPLETING THE APPLICATION

Section A - Patient and Guarantor 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 - Income

1. Your Adjusted Gross Income	☐ per month ☐ per year
2. Spouse's Adjusted Gross Income	☐ per month ☐ per year
3. Other Income	☐ per month ☐ per year
4. Other Income	☐ per month ☐ per year
5. Total Monthly Income	
Description of Other Income	

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

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Section C - Essential Living Expenses

		Monthly Payment
1. Household ☐ Own ☐ Rent		$
2. Utilities Electric, Gas, Water, etc.		$
3. Telephone		$
4. Food		$
5. Automobile(s)	Payments	$
	Insurance	$
6. Other Monthly Obligations for Essential Living Expenses, please list		
a)		$
b)		$
c)		$
d)		$
e)		$
f)		$
7. Total Monthly Essential Living Expenses		$

Section D - Required Documentation

Please provide a copy of the most recent income tax return filled with the IRS. You may also provide other evidence or documentation supporting the information provided in sections B and C.

Section E - Certification

I certify that the information on this application is a true and complete statement of the facts accounting 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 financial assistance.

Signed: _____ Date: _____

Encompass Internal Use Only:

Date Received: _____

Controller Received: _____ Date: _____
Signature

Administrative Approval / Denial: _____ Date: _____
(circle one) Signature

Level of Financial Assistance: ☐ Free ☐ Discount (amt)

If discounted, total monthly income less total essential living expenses

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