Financial Assistance Application Form

ORLANDO REHABILITATION HOSPITAL

PATIENT NAME IN FULL	☐ M ☐ F	AGE	DATE OF BIRTH

ARE YOU A CITIZEN OF THE UNITED STATES	RESIDENT OF OKLAHOMA	HAVE YOU APPLIED FOR MEDICAL ASSISTANCE (MEDICAID)	IF YES, INDICATE MONTH	YEAR
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

ARE YOU OR YOUR SPOUSE SELF-EMPLOYED	DID YOU FILE A FEDERAL TAX RETURN	STATE TAX RETURN	DO YOU HAVE THIRD-PARTY INSURANCE COVERAGE
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION

APPLICANT			APPLICANT'S SPOUSE		
NAME			NAME		
ADDRESS			CITY	STATE	ZIP CODE
PHONE NUMBER ( )	CELL PHONE ( )		PHONE NUMBER ( )	CELL PHONE ( )	
SOCIAL SECURITY NUMBER			SOCIAL SECURITY NUMBER		
EMPLOYER			EMPLOYER		
IF UNEMPLOYED, LAST DATE WORKED			IF UNEMPLOYED, LAST DATE WORKED		
DATE LAST CHECK RECEIVED			DATE LAST CHECK RECEIVED		

FAMILY AND PATIENT INFORMATION

FAMILY MEMBERS LIVING IN THE HOME

NAME	DATE OF BIRTH	AGE	RELATIONSHIP	SOCIAL SECURITY NUMBER

FAMILY INCOME
List Amounts of Each

Patient	SALARY / WAGES / TIPS	INTEREST / DIVIDENDS	ALIMONY	SOCIAL SECURITY	PENSION / RETIREMENT
	DISABILITY	UNEMPLOYMENT	WORKERS COMP	SELF EMPLOYMENT - ATTACH SCHEDULE C	
Spouse	SALARY / WAGES / TIPS	INTEREST / DIVIDENDS	ALIMONY	SOCIAL SECURITY	PENSION / RETIREMENT
	DISABILITY	UNEMPLOYMENT	WORKERS COMP	SELF EMPLOYMENT - ATTACH SCHEDULE C	

FAMILY RESOURCES

Checking Account(s)		
Savings Account(s)		
IRA / 401K / 430B		
Food Stamps (list amount received)	WIC ☐ No ☐ Yes (Need Qualifying Letter)	LOW INCOME HOUSING ☐ No ☐ Yes (Need Qualifying Letter)

PROPERTY (HOUSE OR PERSONAL PROPERTY OTHER THAN YOUR RESIDENCE) - *DESCRIPTION AND LOCATION*	MARKET VALUE
	$
IS THIS HOSPITAL SERVICE / PHYSICIAN SERVICE A RESULT OF A PERSONAL INJURY/ACCIDENT CASE FROM WHICH YOU EXPECT TO RECEIVE A SETTLEMENT ☐ Yes ☐ No	IF YES, EXPECTED AMOUNT $

I hereby acknowledge that I have read this document. It has been provided in printed format or explained to me in my native language and was understood. I certify that all information regarding income and assets are true. I understand that the information which I submit concerning my income, assets, liabilities, and family size is subject to verification. I hereby authorize the release of any necessary information from individuals, universities or colleges, businesses, public or private organizations to determine my eligibility. I assign and transfer to Reunion Rehabilitation Hospital Jacksonville all my rights to benefits, monies, and sums payable to me for hospitalization, sickness, or accident liability coverage. I understand that failure to disclose information and/or payments will result in denial of the application.

PATIENT - SIGNATURE	DATE	TIME

PERSON COMPLETING FORM, IF OTHER THAN PATIENT - SIGNATURE	RELATIONSHIP TO PATIENT	DATE	TIME

INTERPRETER / WITNESS - SIGNATURE

DATE TIME

PATIENT LABEL