OhioHealth
Rehabilitation Hospital
In partnership with Select Medical

FINANCIAL HARDSHIP DISCLOSURE FORM

(Based on annual household GROSS income and dependents)

Patient Name: _____ _____ **DOB:** _____
Last **First**

Spouse/Partner: _____ _____
Last **First**

Patient Address: _____
Mailing/Street Address

_____ _____ _____
City **State** **Zip Code**

Annual Household GROSS Income: $

Number of Household Members (patient, patient's spouse/partner, and dependents): Adults: Minors:

Insurance Plan: _____

Patient Deductible/Copay/Coinsurance: _____

Is therapy due to WC, MVA or liability claim? Yes ☐ No ☐

If yes, do you have an attorney? Yes ☐ No ☐

Attorney's name: _____ Phone: _____

INCOME DOCUMENTATION MUST BE PROVIDED WITH APPLICATION TO MAKE A DETERMINATION. INCOME DOCUMENTATION REQUIRED IS THE MOST RECENT FEDERAL INCOME TAX RETURN AND PROOF OF INCOME FOR ALL HOUSEHOLD MEMBERS TO INCLUDE, BUT NOT LIMITED TO: 3 MOST-RECENT PAYSTUBS, SOCIAL SECURITY STATEMENT, DISABILITY OR RETIREMENT PAYMENTS, ETC. IF NOT REQUIRED TO FILE A FEDERAL TAX RETURN, MEDICARE PATIENTS MAY SUBMIT A COPY OF THEIR SOCIAL SECURITY STATEMENT FOR THE CURRENT YEAR SHOWING THE GROSS MONTHLY AMOUNT RECEIVED. ADDITIONAL INFORMATION MAY BE REQUESTED TO ASSIST IN MAKING A DETERMINATION.

I, the undersigned, certify that the above information is true and accurate. I understand that if I provide false or inaccurate information, I will be excluded from applying for or participating in the Financial Hardship program for a period of at least one year, at the discretion of Select Medical. I also understand that waiver amount may change if additional information is determined to affect the Financial Hardship.

Parent / Guardian Signature	Printed Name	Date
Witness Signature	Printed Name	Date
Amount of waiver based on financial hardship (to be completed by CBO)	_____%	
CBO Client Services Supervisor Approval Signature	Printed Name	Date
CBO Client Services Manager Approval Signature	Printed Name	Date
Center	Patient Account Number	Database