Palomar Health Rehabilitation Institute Financial Assistance Application

You may apply for Charity Care (free care) or Discounted Payment (reduced charges). If you apply only for Discounted Payment, you may receive less assistance than under Charity Care.

Patient Information

Patient Name _____

Address _____

Phone Number _____

Date of Birth _____

Social Security Number _____

Insurance Coverage

Do you have health insurance _____

Guarantor _____

Guarantor Account Number _____

Do you have other insurance that may apply (such as an auto policy)

_____

Were your injuries caused by a third party (such as car accident or slip and fall)

_____

Family Status

Adult Patients: For patients eighteen (18) years of age and older (except for dependent children aged 18-20, addressed below) the patient family includes their spouse, domestic partner, dependent children under twenty-one (21) years of age, and a dependent child of any age if the dependent child is Disabled. Children meeting the criteria in this subsection are considered part of the family whether living at home or not.

Dependent Child Aged 18-20: For patients who are dependent children aged eighteen (18) to twenty (20), inclusive, the patient family includes their parent(s), caretaker relative(s), other dependent children under twenty-one (21) years of age of the parent(s) or caretaker relative(s), and a child of the parent(s) or caretaker relative(s) of any age if the child is disabled.

Name, Age, Relationship _____

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Name, Age, Relationship _____

Name, Age, Relationship _____

Employment and Occupation

Employer _____

Position _____

Contact Person and Telephone _____

Name of Business if Self-Employed _____

Current Monthly Income

Provide ONE of the following: (a) Recent tax return documenting income for the year first billed or prior 12 months; OR (b) Recent pay stubs within a 6-month period before or after first billing (or when application is submitted for preservice).

Include: patient and family

Gross Pay (before deductions) _____

Income from Operating Business (self-employed) _____

Total Monthly Income (patient and family) _____

Certification

The purpose of this information is to determine your ability to pay for services at PHRI or your possible eligibility for a medical assistance program. This information is NOT an application for Medi-Cal, or any other county's assistance program. YOU MUST CONTACT THE DEPARTMENT OF SOCIAL SERVICES IN YOUR COUNTY OF RESIDENCE TO APPLY FOR ASSISTANCE PROGRAMS. I certify the above information to be accurate and complete. I understand that the hospital reserves the right to verify all information supplied. I agree to notify the PHRI Director of Finance (442) 277-6202 of any change in my financial information within 10 days of the change.

Signature_____

Date_____