Ballard Rehabilitation Hospital
Application for Financial Assistance

Contact Information

Please provide us with the following patient contact information:

Patient Name_____
Name_____
Street Address_____
City, State, Zip_____
Telephone Number_____

Please provide us with the responsible party's contact information:

Name_____
Relationship to patient_____
Street Address_____
City, State, Zip_____
Telephone Number_____

Financial Information

Income (include your information and information from all family members within the same household. Please provide us the following information regarding your income:

Your earned income (employment):_____
Employer Name_____
Address_____
Amount last year$_____
Other family members income$_____
Other income$_____

Total interest, dividend, other_____

Please attach a copy of your most recent tax return (required)

Monetary Assets

If you are applying for assistance under our charity care plan, you must provide information regarding assets.

Bank accounts
Most recent balance (all accounts)$_____
Bonds$_____
Face value (all bonds, bond funds)_____
Other liquid assets$ _____
Total value$ _____

Please attach a copy of all statements related to the assets listed above (bank, brokerage accounts, etc.)

Applicant Attestation and Signature

Under penalty of perjury, I attest that the above information is correct and provide an accurate Picture of my income and, if applicable, my monetary assets. I understand that if I have not provided accurate information, my application may be denied. I further understand that completion of this application for financial assistance does not guarantee eligibility under the program.

Patient or responsible party signature_____Date_____
Printed_____
Relationship to patient_____