Continental Rehabilitation Hospital of San Diego
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 list above (bank, brokerage accounts, etc.)

Applicant Attestation and Signature

Under the 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	