

**Madonna Rehabilitation Hospital
Financial Resource Assessment**

Patient Name:

Date of Birth:

Patient/Guarantor	Spouse
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Name:	Name:
Age: Martial Status:	Age: Martial Status:
Present Address No. Years _____ Own ____ Rent ____	Present Address No. Years _____ Own ____ Rent ____
Street:	Street:
City/State/Zip	City/State/Zip
Total Number Residing in Household:	Total Number Residing in Household:
Number of dependent children: _____ Age(s) _____	Number of dependent children: _____ Age(s) _____
Name of Employer:	Name of Employer:
Position/Title:	Position/Title:
Length of Employment:	Length of Employment:

Monthly Income			Monthly Expense		
	Guarantor	Spouse	Total		
Gross Wages				Mortgage/Rent	
Farm/Self-employed				Utilities	
Pensions				Gas	
Workers Compensation				Electric	
Interest/Dividends				Water	
Rental				Garbage Pickup	
Disability/SSI/SSD				Cable TV	
Military				Land line and/or Cell Phone	
Child Support				Auto Loan Payment(s)	
Alimony				Child Care Expense(s)	
				Clothing	
Unemployment					
Public Assistance				Credit Card (minimum payment)	
Other				Entertainment/Recreational Activities	
Total monthly household income:				Medical/Medicine/Supplies	
				Total monthly household expenses:	
Total Assets			Total Liabilities		
Checking Account:				Mortgage Loan	
Savings Account:				Home Owners Insurance (if not included in mortgage pmt)	
Money Market, CD, IRA:				Auto Loan	
Stocks/Bonds:				Vehicle Licensing Tax	
401K				Credit Card Debt	
Real Estate Assessed Value				Medical expenses for deductible/co-pay/Out of pocket and/or patient responsibility	
Other Assets (boats, motorcycles, campers)				Other	
Total Assets				Total Liabilities	

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Federal/State Assistance Programs

Have you applied for Medicaid or other government assistance programs? YES _____ NO _____

If yes, what type of program? _____

What date was the application made? _____

If known, what is the case workers name and contact information? _____

Is the patient a US Citizen: Yes _____ No _____

Power of Attorney - Guardian/Conservator Information

Do you have a designated Financial Power of Attorney or a court appointed Guardian/Conservator to act on your behalf? If yes, please provide the following information and copies of your document(s).

Name: _____

Address: _____ Phone: _____

Health Insurance Coverage Information

Is health insurance coverage available to you through an employer or other source? YES _____ NO _____

Do you participate? YES _____ NO _____

If yes, how was your coverage obtained:

_____ Employer or Spouses Employer ?

_____ Marketplace/Insurance Exchange ? If yes, please provide the following information.

Did you receive a subsidy to assist with your premium? If so, in what amount? _____

When was your last premium payment made? _____

Patient/Guarantor Signature

I certify that all information listed herein is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services rendered to me or my family member by Madonna Rehabilitation Hospital. I also understand that additional supporting documentation may be required to assist with determining financial ability to resolve my outstanding balance and/or determine qualification or consideration for Financial Assistance.

Signature _____ Date _____

Please provide the following proof of income documents :

_____ Federal tax return including W2(s) for year(s) _____

_____ Payroll stubs for last 2 months

_____ Bank statements for the current month and/or other income verification