Madonna Rehabilitation Hospital
Financial Resource Assessment

Patient Name: Date of Birth:

Patient/Guarantor	Spouse
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	Guarantor	Spouse	Total
Gross Wages			
Farm/Self-employed			
Pensions			
Workers Compensation			
Interest/Dividends			
Rental			
Disability/SSI/SSD			
Military			
Child Support			
Alimony			
Unemployment			
Public Assistance			
Other			
Total monthly household income:			

Monthly Expense	
Mortgage/Rent	
Utilities	
Gas	
Electric	
Water	
Garbage Pickup	
Cable TV	
Land line and/or Cell Phone	
Auto Loan Payment(s)	
Child Care Expense(s)	
Clothing	
Credit Card (minimum payment)	
Entertainment/Recreational Activities	
Medical/Medicine/Supplies	
Total monthly household expenses:	

Total Assets	
Checking Account:	
Savings Account:	
Money Market, CD, IRA:	
Stocks/Bonds:	
401K	
Real Estate Assessed Value	
Other Assets (boats, motorcycles, campers)	
Total Assets	

Total Liabilities	
Mortgage Loan	
Home Owners Insurance (if not included in mortgage pmt	
Auto Loan	
Vehicle Licensing Tax	
Credit Card Debt	
Medical expenses for deductible/co-pay/Out of pocket and/or patient responsibility	
Other	
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