

**Buckeye Health & Rehabilitation**  
**FINANCIAL HARDSHIP APPLICATION**

**Patient Name:** \_\_\_\_\_ **Chart #:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Month of Service:** \_\_\_\_\_ **Family Member Interviewed:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_ **Responsible Party:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Patient's Social Security #:** \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

Do you have health insurance covering these services? \_\_\_\_\_ If yes, enter information below and attach copy of insurance card.

Name of Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Do you have Medicaid benefits? \_\_\_\_\_ If yes, enter billing # \_\_\_\_\_ & attach copy of Medicaid card.

Do you have Disability Assistance (DA) benefits? \_\_\_\_\_ If yes, enter billing # \_\_\_\_\_ & attach copy of DA card.

Please list all "family" members (including yourself). Family members include parents, spouses & children (natural or adoptive) under the age of eighteen (18) living in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, social security benefits, public assistance, etc.

Family Members	Age	Relationship	Source of Income	Income 3 mths prior to date of service	Income for 12 mths prior to date of service

If you reported \$0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested above.

I affirm that the answers on this application are true.

Responsible Party Signature \_\_\_\_\_ Date Completed \_\_\_\_\_

Signature of Buckeye Health & Rehabilitation Representative \_\_\_\_\_ Date Signed \_\_\_\_\_

**A new and updated application is required for each month in which services are provided.**