HONORHEALTH™

- ☐ Deer Valley Medical Center
- ☐ John C. Lincoln Medical Center
- ☐ Scottsdale Osborn Medical Center
- ☐ Scottsdale Shea Medical Center
- ☐ Scottsdale Thompson Peak Medical Center

FINANCIAL ASSISTANCE DISCLOSURE

- **Thank you for completing the information below. In addition to the completed form, we will need a copy of last year's tax return, W2's, 2 most recent pay stubs, 2 current months of any/all bank statements and any other income/asset verifications, including 2 months of all investment accounts. Please return your application and supporting documentation as soon as possible to ensure timely processing.**
- **Financial assistance applies to facility charges only. Discounts do not apply to third parties involved in a patient's care. Examples of third parties involved in patient's care include but are not limited to Emergency Room Physicians, Pathologists, Radiologists, and Anesthesiologists.**

PATIENT INFORMATION		
Patient Name	**Account #**	**Estimate/Balance**
SS#	**Date of Birth**	
Relationship to Guarantor		

GUARANTOR INFORMATION		
Name		
SS#		**Birthdate**
Address		**Phone**
City	**State**	**Zip**
Employer	**Length of Employment**	**Est Gross Income**
Income from Other Sources (eg, child support, alimony, retirement)		

SPOUSE INFORMATION		
Name		
SS#		**Birthdate**
Address		**Phone**
City	**State**	**Zip**
Employer	**Length of Employment**	**Est Gross Income**
Income from Other Sources (eg, child support, alimony, retirement)		

DEPENDENT INFORMATION		
Name (Last, First, Middle Initial)	**Relationship**	**Date of Birth**

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BANK INFORMATION		
Bank Name	**Checking Balance**	**Savings Balance**
Bank/Credit Union Name	**Checking Balance**	**Savings Balance**

EXPENSES		
	Balance	**Monthly Payment**
Mortgage/Rent		
Home Equity Value		
Car (Make, Year, Model)		
Food/Household Supplies		
Gasoline/Transportation		
Utilities		
Telephone		
Child Care		
Insurance		
Student Loans		
Child/Spousal Support		
Medical Expenses		
Credit Cards (Specify Each)		
TOTAL MONTHLY EXPENSES		

I certify that the information provided in this financial disclosure worksheet and on any attachments is accurate and complete to the best of my knowledge. By signing below, I authorize HonorHealth to verify any credit and employment history, including running a credit report as necessary to assess financial need. I further understand that I must update this information if requested and/or if my financial situation changes.

_____ _____

Applicant Name **Date**

☐ **Proof of income attached**

PROVIDER ONLY – DO NOT USE		
Total Annual Income	**Number in Family**	**Total Expenses**
Total approved for charity/installments	**Date Determination Letter Mailed**	
Authorization Level I	**Authorization Level II**	