HONORHEALTH

Deer Valley Medical Center
Florence Hospital
Greenbaum Specialty Hospital
John C Lincoln Medical Center
Four Peaks Medical Center
Scottsdale Osborn Medical Center
Scottsdale Shea Medical Center
Scottsdale Thompson Peak Medical Center
Sonoran Crossing Medical Center
Tempe Medical Center

HonorHealth Free-Standing Emergency Departments, Urgent Cares and Medical Group Locations

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 for everyone in the household 18 years and older. Please return your application via email at financialassistance@honorhealth.com or fax to 480-882-6081 along with supporting documentation as soon as possible to ensure timely processing.

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		
Mortgage/Rent	**Balance**	**Monthly Payment**
Home Equity Value		
Car (Make, Year, Model)		
Food/Household Supplies		
Gasoline/Transportation		
Utilities		
Telephone		
Child Care		
Insurance		
Student Loans		
Child/Spousal Support		
Medical Expenses (see below) *		
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**

* A household with medical expenses incurred during the previous 12 months for which the household is responsible for which exceeds 50% of the household's total income for that year. All medical expenses, including non-HonorHealth medical expenses, are included for the purposes of determining whether a household is Medically Indigent. HonorHealth will need copies of the documentation.