



Deer Valley Medical Center
 Florence Medical Center
 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 Medical Group Locations

FINANCIAL ASSISTANCE DISCLOSURE

To continue processing your application, please submit supporting income documentation for all household members aged 18 and older. You may submit your completed application and documents using one of the following methods:

- Email: financialassistance@honorhealth.com
- Fax: 480-882-6081
- MyChart: Follow the on-screen prompts to apply and upload your documents securely.
- Submitting your application promptly will help ensure timely review and processing.

PATIENT INFORMATION		
Patient Name	Account #	
SS#	Date of Birth	
Employer	Full or Part-Time	

GUARANTOR INFORMATION		
Guarantor Name		
SS#	Date of Birth	
Address	Phone	
City	State	Zip
Employer	Full or Part-Time	

SPOUSE INFORMATION		
Guarantor Name		
SS#	Date of Birth	
Address	Phone	
City	State	Zip
Employer	Full or Part-Time	

DEPENDENT INFORMATION		
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth



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INCOME TYPE – Provide Supporting Documentation		
Income Type, as applicable	Frequency: Weekly, Bi-Weekly, Monthly or Other	Amount
Alimony		
Child/Spousal Support		
Gift		
Gov’t Assistance <small>Provide documentation</small>		
Pension <small>Provide statement</small>		
Social Security <small>Provide statement</small>		
Tax Return <small>Provide previous year</small>		
Wages <small>Provide last 2 pay stubs</small>	Full or Part-Time	
Wages <small>Provide last 2 pay stubs</small>	Full or Part-Time	
W2s <small>Provide previous year</small>		
Other <small>(ex: letter from someone assisting you financially)</small>		
Bank/Credit Union Name <small>Provide last 2 complete statements</small>		
Bank/Credit Union Name <small>Provide last 2 complete statements</small>		
List Medical Expenses <small>Provide copies of outstanding bills</small>		

I certify that the information provided in this financial disclosure worksheet, along with any attached documentation, is accurate and complete to the best of my knowledge. By submitting this application either electronically or by hand, I acknowledge that this submission serves as my signature. I authorize HonorHealth to verify my credit and employment history, including obtaining a credit report if necessary to assess financial need. I understand that I am responsible for updating this information upon request or if my financial situation or circumstances change.

Applicant Printed Name and Signature

Date

A household may be considered medically indigent if it has incurred medical expenses during the previous 12 months that exceed 50% of the household’s total annual income. This includes all medical expenses, whether from HonorHealth or other providers. To determine eligibility, HonorHealth requires documentation of these expenses and income.