# Burke Rehabilitation Hospital: Charity Care Application:

Patient's Name:_____

Date Sent: _____ Date to Return _____ ASAP_____

Number of Persons in Family _____

Family Income Last Twelve (12) months _____

Patient's Income Last Twelve (12) months _____

Family Income Last Three (3) months _____

Patient's Income Last Three (3) months _____

If you are seeking charity care for services already rendered by The Burke Rehabilitation Hospital, please list dates of service. If you are seeking an eligibility determination for services not yet rendered, check type of services sought.

Inpatient_____ Outpatient __ _____

Expected Date of Service _____ Dates of Service _____

I understand that the information that I submit is subject to verification by the Burke Rehabilitation Hospital and subject to review by Federal and/or State Enforcement Agencies and others required. I certify that the above information is true and correct.

Signature of Person Making Request_____

DO NOT COMPLETE BELOW-FOR HOSPITAL PERSONNEL ONLY

This document was received on _____By: _____ of Patient Financial Services.

The following documents were provided to verify income and family composition. Return all originals to Patient. Paychecks stubs _____, Income Tax Forms_____,

Other _____.

Notes:

Revised 11/2023