REHAB Hospital of the Pacific
Dedicated to Rebuilding Lives

Aloha,

Consistent with our mission and values, the Rehabilitation Hospital of the Pacific (REHAB) is committed to providing financial assistance to patients needing medically necessary rehabilitative healthcare services and are unable to pay based on their individual financial situation. Our financial assistance program allows uninsured and underinsured patients meeting eligibility requirements to receive financial support to help pay for eligible medically necessary care.

REHAB's financial assistance program applies only to eligible services as described in our Financial Assistance Policy (FAP). Services that are provided by non-REHAB providers at REHAB locations are not eligible under our FAP and may be billed to patients separately.

For eligibility you must be a United States citizen or a legal alien who permanently resides in Hawaii. Your family's assets and income will be reviewed to see if they meet policy guidelines for awarding financial assistance. If they do, your REHAB bills will be discounted. The actual amount of the discount depends on your family income.

To apply, please fully complete this Application for Financial Assistance. You must attach recent documentation with your application to support your responses. The ***Financial Assistance – Documentation Checklist*** (attached) details the requested information.

Information that you share with us will be used only for the purpose of this application. It will be treated as confidential information.

Please submit your completed application and copies of supporting documentation to the Patient Financial Services department located on the first floor of REHAB Hospital or mail it to:

The Rehabilitation Hospital of the Pacific
ATTN: Patient Financial Services
226 North Kuakini Street
Honolulu, HI 96817

If you have any questions, please contact REHAB's Patient Financial Services at (808) 544-3340.

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Financial Assistance - Documentation Checklist

When submitting your application, please include copies of the following documents, as appropriate, which are required to support your Application for Financial Assistance:

- ☐ Driver's License, Birth Certificate and/or other picture ID or alien card;
- ☐ Most recent Federal and State income tax returns
- ☐ Documents which reflect your family's income, including:
  - Pay stubs or W-2's
  - Social security statements or award letters
  - Documents showing public assistance funded or award letters
  - Determination of Insured Status letter for unemployment benefits
  - Benefit award letter for worker's compensation
  - Monthly statement for pension/retirement benefits
  - Monthly statement for veteran's benefits
  - Benefit award letter for child support or alimony
  - Monthly statement for rental income
- ☐ Recent statements from other hospitals, physicians, laboratories, etc. showing amounts owed on family medical bills
- ☐ Documents showing your family's liquid assets, including:
  - Monthly statements from financial institutions showing balances, interest income, and dividends
  - Documents showing other family liquid assets
- ☐ Submitted Medicaid application from the State of Hawaii and approval/denial letter

If none of these documents are available, please provide a written explanation as to why such documents were not submitted with your completed application.

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APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

Patient Name:	Social Security#:	Date of Birth:	Patient/Guarantor Home Phone:
Guarantor Name:	Social Security#:	Date of Birth:	Patient/Guarantor Cell Phone:

Patient/Guarantor's Permanent Address:

U.S. Citizen: ☐ Yes ☐ No

Patient/Guarantor Email:

FAMILY MEMBERS IN HOUSEHOLD

Name:	**Relationship:**	**Date of Birth:**	**Social Security#:**
Name:	**Relationship:**	**Date of Birth:**	**Social Security#:**
Name:	**Relationship:**	**Date of Birth:**	**Social Security#:**
Name:	**Relationship:**	**Date of Birth:**	**Social Security#:**

EMPLOYMENT INFORMATION

Patient/Guarantor's Employer & Address: Job Title:

Spouse's Employer & Address: Job Title:

FAMLY LIQUID ASSETS: *List total liquid assets for all family members* (Must attach copies of supporting documents)

Bank/CU Checking Accts: $	Bank/CU Savings Accts: $	Money Market Accts: $	Cash on Hand: $
Investments (stocks/ bonds): $	Other (specify): $	Other (specify): $	Other (specify): $

FAMILY INCOME: *List total income for all family members* (Must attach copies of supporting documents)

Wages/salary: $	Social Security: $	Public Assistance/Unemployment: $	Worker's Comp: $
Pension/Retirement: $	Rental: $	Child Support/Alimony: $	Veteran's Benefit: $
Other (specify): $			

FAMILY MEDICAL EXPENSES: *List total expenses for all family members* (Must attach copies of supporting documents)

Provider (Hospital/Doctor/Lab):	Amount Owed: $	Type of service(s):	Mo/Yr of Svcs:
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ADDITIONAL INFORMATION

Have you applied for Medicaid or other financial programs? ☐ Yes ☐ No If YES, date of application:

Results of application, please specify:

Are there any pending lawsuits, settlements, awards related to your services at REHAB? ☐ Yes ☐ No

Describe:

STATEMENT OF APPLICANT: I certify that the above information is true and accurate to the best of my knowledge. I understand that REHAB may verify any and all of the information provided. If any information proves to be false, I understand that I will not be eligible for financial assistance at REHAB and I will be liable for charges for services provided.

I agree to cooperate fully with REHAB by applying for any financial assistance (including applying for Medicaid/Quest) available to me to pay for my REHAB charges. I understand that all other insurance and third party sources of payment must be applied to charges before financial assistance will be applied. I will assign or pay to REHAB any amount covered for these charges from any source, such as a settlement, judgment or insurance.

I understand that this assistance covers only eligible medically necessary services provided by REHAB. Further, I understand that REHAB may revoke my financial assistance coverage at any time for any reason.

Printed Name: _____ Signature: _____ Application Date: _____ Relationship to Patient: _____