HONORHEALTH

Deer Valley Medical Center
Florence Hospital
Greenbaum Specialty Hospital
John C Lincoln Medical Center
Mountain Vista Medical Center
Scottsdale Osborn Medical Center
Scottsdale Shea Medical Center
Scottsdale Thompson Peak Medical Center
Sonoran Crossing Medical Center
Tempe St. Lukes Hospital

HonorHealth 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, fax 480-882-6081 or MyChart 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.