



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 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		
	Balance	Monthly Payment
Mortgage/Rent		
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.