ALLIED SERVICES INTEGRATED HEALTH SYSTEM

APPLICATION FOR UNCOMPENSATED FINANCIAL ASSISTANCE

(PLEASE PRINT)

Please indicate which facility

_____ Allied Rehab Hospital, Scranton, PA _____ Heinz Rehab Hospital, Wilkes-Barre Township, PA

_____ Home Health _____ Other _____

Patient Name_____
Last First Middle Initial

Address_____
Number & Street City State Zip

Home Phone (____)_____ Social Security Number_____

Cell Phone (____)_____ Date of Birth _____

Employer_____ Occupation_____

Street Address_____ Work Phone (_____)_____

City, State_____ Zip_____

Spouse's Employer_____ Occupation_____

Street Address_____ Work Phone (_____)_____

City, State_____ Zip_____

Family Income: *

Description	Last 3 Months Gross Income	Last 12 Months Gross Income
Wages/Self-employment	_____	_____
State Assistance	_____	_____
Social Security/Disability	_____	_____
Unemployment/Workers Comp	_____	_____
Pension	_____	_____
Other Income	_____	_____

**Please attach documentation.*

(Continued on Reverse)

Income Verification: As a condition to receiving Financial Assistance, you must attach copies of the following items for each household member providing income.

Latest Federal Income Tax return

Pay stubs for the 3 most recent months or a benefit statement for the current year (i.e. social security, unemployment compensation, etc.).

Family Size (list all family members in your household)

Name	Relationship	Age

Total Family Members (including applicant) _____

Mail your application to:

Allied Services
Patient Finance Department
UFA Program
100 Executive Park
Clarks Summit, PA 18411

For assistance call:
877-727-3422
570-348-1372

I certify that the above information is true and accurate to the best of my knowledge. Further I will apply for any assistance (Medical Assistance, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. I further understand that the information which I submit concerning my annual family income and family size is subject to verification by Allied Services. I also understand that if any information I have given is determined to be false, or if I fail to apply for other third-party assistance, such a determination will result in a denial of providing services as uncompensated care and I will be liable for the charges of the services provided.

_____ _____

Date of Request Applicant's/Guardian Signature