Easterseals Rehabilitation Center
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Application for Fee Reduction for Therapy Services

Durable Medical Equipment excluded

Top line to be completed by Easterseals Rehabilitation Center staff only	Date Application Received	Amount of Fee Reduction Approved	Date of Determination	Income verified by

Please provide the following information completely and accurately. Information is subject to verification.
Please attach a list of additional household members if there are more than five (5) members.

Client Name (First, MI, Last):	Social Security Number:	Total # Household Members:
Address:	Telephone Numbers: Home: ( ) Cell: ( )	
City/ST/Zip:	Responsible Party Name (First, MI, Last):	

List ALL household member names	Date of Birth	Soc Sec Number	Relationship to patient	Monthly Income
1.		- -	Self	$
2.		- -		$
3.		- -		$
4.		- -		$
5.		- -		$

Monthly Income		Monthly Expenses	
Responsible Party’s Gross Income (before taxes)	$	Rent/Mortgage/Homeowner’s Insurance	$
Other Household Gross Income (before taxes)	$	Utilities (Electricity/ Water/Gas)	$
Disability Income	$	Telephone	$
Child Support/Alimony Received	$	Child Support/Alimony Paid	$
Social Security	$	Food (excluding cigarettes & alcoholic beverages)	$
Pension/Retirement/Unemployment	$	Medical & Pharmacy Bills	$
Other:	$	Other:	$
Total Monthly Income (before taxes)	$	**Total Monthly Expenses**	$

In order to determine eligibility the following documents ARE REQUIRED:

- Proof of gross wages, salaries, tips, Social Security, SSI, veterans benefits, etc.
- Employer pay stubs for last three consecutive pay periods for each employed family member
- Most recent Individual Federal 1040 tax form (page 1-2)

I certify that the information provided above is an accurate representation of my financial information.

I also certify that there is no additional insurance coverage other than what was listed at time of intake. I agree to make application for any assistance (Medicaid, Medicare, Insurance, etc.) that may be available for payment of my therapy charges. I will do whatever I can do to obtain the assistance and will assign or pay Easterseals Rehabilitation Center the amount recovered for therapy charges.

If my financial situation changes from what is listed above (changes in insurance coverage, job changes or for any other reason) I agree to notify Easterseals Rehabilitation Center immediately. Additionally, if a third-party liability arises from an accident, workers comp claim or any other reason charges will be adjusted back based upon that new information.

I understand that any fee reduction applied to my account will be reversed if my balance falls into collections status and I will be responsible for the account balance in full.

I understand that providing false information will result in denial of the application for any type of financial assistance through the Easterseals Rehabilitation Center.

______________________________________ ___________________________

Signature of Client / Responsible Party Date