



**BURKE REHABILITATION HOSPITAL  
CHARITY CARE APPLICATION**

Patient's Name: \_\_\_\_\_

Date Sent: \_\_\_\_\_ Date to Return \_\_\_\_\_ ASAP \_\_\_\_\_

Number of Persons in Family \_\_\_\_\_

Family Income Last Twelve (12) months \_\_\_\_\_

Patient's Income Last Twelve (12) months \_\_\_\_\_

Family Income Last Three (3) months \_\_\_\_\_

Patient's Income Last Three (3) months \_\_\_\_\_

If you are seeking charity care for services already rendered by The Burke Rehabilitation Hospital, please list dates of service. If you are seeking an eligibility determination for services not yet rendered, check type of services sought.

Inpatient \_\_\_\_\_ Outpatient \_\_\_\_\_

Expected Date of Service \_\_\_\_\_ Actual Dates of Service \_\_\_\_\_

I understand that the information that I submit is subject to verification by the Burke Rehabilitation Hospital and subject to review by Federal and/or State Enforcement Agencies and others required. I certify that the above information is true and correct.

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Signature of Person Making Request

**DO NOT COMPLETE BELOW--FOR HOSPITAL USE ONLY**

This document was received on \_\_\_\_\_

By: Janis Coppa, Supervisor of Patient Financial Services

The following documents were provided to verify income and family composition.  
Return all originals to Patient.

Paychecks stubs \_\_\_\_\_

Income Tax Forms \_\_\_\_\_

Other (specify) \_\_\_\_\_