Financial Assistance Application

(All fields must be completed unless noted otherwise)

Patient Last Name, First	Date of Birth	Social Security Number	*Number of People in Household	Last 12 Months Annual Household Income $
If Minor, Guarantor's Last Name, First	Date of Birth	Social Security Number	Guarantor's Source of Income	
Vehicles in Household including Cars/Boats/RV's (Year/Make/Model) (Optional)	Checking/Savings Account Balance (Optional)	Properties Owned and Values (Optional)	CD/Retirement/ Investment Account Balances (Optional)	Other Assets (Optional)
Patient Street Address		Home Phone Number	If income is $0, please check one:	
City, State, Zip Code		Alternate Phone Number		Lives with Relative(s)
Number of children under age 21 in the home: _____				Lives with Friend(s)
				Retired
				Unemployed
				Disabled
				Homeless

Please read before signing. I CERTIFY that the information I have provided is true and accurate to the best of my knowledge. I will independently or with the assistance of hospital personnel apply for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay this hospital bill. I understand that if I do not cooperate with my hospital provider in providing requested information, my application may be denied for possible financial assistance. I hereby grant permission and authorize any accredited agent of the Medicaid program to disclose to my hospital provider ALL information regarding the status of my Medicaid application and if the application is not approved and the reason for disapproval. I will ASSIGN to my hospital provider ALL FUNDS received from the above sources, which are provided to help with this HOSPITAL BILL. I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain in strictest confidence any written communication and/or oral discussions between me and my hospital provider regarding matters relating to services provided to me by my hospital provider. I understand that the information which I submit is subject to verification by my hospital provider, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I AUTHORIZE my employer to release to my hospital provider my proof of income. I UNDERSTAND that if any information I have given proves to be untrue, my hospital provider will re-evaluate my financial status and take whatever action becomes appropriate. **To qualify for assistance, at least one piece of supporting documentation that verifies household income may be required. Supporting documentation can include but is not limited to, most recent year's tax return, a current W-2, notarized letter of support, etc. Requests for assistance may be denied if supporting documentation is not provided. Any unpaid balance will be eligible for further collection action.** *[State of Florida Applicants: Florida Statute s.817.50 (1). Whoever shall, willfully and with intent to defraud, obtain or attempt to obtain goods, products, merchandise or services from any hospital in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in s.775.082 or s.775-083.]*

Signature of Applicant /Guarantor

Date Completed

* When calculating the number of people in the household, only the following people are counted: 1) Blood relatives living in the home, 2) Relatives by marriage living in the home, and 3) Relatives by legal adoption living in the home.

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Reason for Service	GAI	DOS	Family Size	Total Charges
1.0x $	1.5x $	2.0x $	25% Rule $	
Recommendation for account disposition				
Finance Committee Disposition				
Manager _____ Date _____		Director _____ Date _____		