Appendix D: Financial Assistance Application

Name:_____
First Middle Last

Social Security Number:_____-_____-_____ Marital Status: Single Married Separated

U.S. Citizen Yes No Permanent Resident: Yes No

Relationship to Patient:_____

Home Address:_____ Phone:_____

_____

_____ Country:_____
City State Zip code

Employer Name:_____ Phone:_____

Work Address:_____

_____
City State Zip code

Household Members:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you applied for Medical Assistance: Yes No

If yes, what was the date you applied? _____

If yes, what was the determination?_____

Do you receive any type of state or county assistance? Yes No

1. ***Family Income***
   List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self employment	_____
Other income sources	_____

2. ***Liquid Assets***

	Current Balance
Checking account	_____
Savings account	_____
Stock, bonds, CD, or money market	_____
Other accounts	_____

3. ***Other Assets***

If you own any of the following items, please list the type and approximate value.

Home Loan balance _____ Approximate value_____

Automobile Make _____ Year_____ Approximate value _____

Additional vehicle Make _____ Year_____ Approximate value _____

Additional vehicle Make _____ Year_____ Approximate value _____

Other property Approximate value _____

Total:_____

4. ***Monthly Expenses*** Amount

Rent or Mortgage _____

Utilities _____

Car payment(s) _____

Credit card(s) _____

Car insurance _____

Health insurance _____

Other medical expenses _____

Other expenses _____

Do you have any other unpaid medical bills? Yes No

For what service?_____

If you have a payment plan, what is the monthly payment?_____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination.

I understand that in accordance with Florida Statues 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree.

_____ _____ _____
Applicant Signature Relationship to Patient Date

_____ _____
Witness Signature Date