FINANCIAL ASSISTANCE APPLICATION FORM- FLAGLER HEALTH+

**SECTION ONE: PATIENT INFORMATION**

Account Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Service\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residential Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street # and Name City State Zip County

Date of Birth\_\_\_\_\_\_⁄\_\_\_\_\_\_\_\_⁄\_\_\_\_\_\_ Marital Status: Single Married Divorced

Primary Phone Number (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance at the time of service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION TWO: INCOME INFORMATION**

Provide below a listing of all sources of income for the last 12 months for yourself and your spouse

|  |  |
| --- | --- |
| **Income Source** | **Gross income for the last 12 months** |
| Wages/Self-Employment/Social Security |  |
| Unemployment or Worker’s Compensation |  |
| Child Support (only if you are the recipient) |  |
| Rental Income, Pension, Dividends, Other |  |

**SECTION THREE: FAMILY SIZE INFORMATION**

Provide below a listing of all qualifying family members, including yourself/the patient at time of service

|  |  |  |
| --- | --- | --- |
| **Name of Family Member** | **Age or Full Date of Birth** | **Relationship to Patient** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

I certify that the information submitted on this form is true and accurate to the best of my knowledge knowing that all information may be verified by the hospital. Further, I will make application and take any reasonably necessary actions for any assistance to acquire payment for my hospital charges.

In accordance with Public Law 79-725, s.817.50, providing false information to defraud the hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree.

Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital Use Only: Approval Signatures**

Reviewer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manager\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Director\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_