Hospital Account #

Date of Service:

Financial Assistance Application

To apply for financial assistance for your hospital bill please complete the attached form and return it to the address below.

It is very important to follow the instructions listed below in order for your application to be reviewed:

- Income information is needed for a full 12 months.
- If the patient is a minor, financial information is needed for the parent or guardian.
- Use blue or black ink only.
- Applications must be signed AND witnessed to be considered for assistance. Notary is not required.

SPECIAL NOTICE TO MEDICARE RECIPIENTS

Medicare regulations require proof of income and assets when determining eligibility for hospital assistance.

Required proofs:

- **Proof of Income: copy of notices from Social Security, Unemployment Compensation, pensions, rental income or ANY income used to pay your expenses**
- **No Income: provide a letter of support from the individual assisting you**
- **Proof of Assets: current bank statement , value of IRA , stocks, bonds, 401k's, whole life insurance policy cash value, and real estate (other than homestead)**

POTENTIAL MEDICAID PARTICIPANTS

- **Are you pregnant OR have a child aged 17 or under in your custody?**
- **Are you between the ages of 18-21 and live with parent(s) or a relative?**
- **Are you over 65 years of age?**
- **Are you receiving Social Security disability?**

If you answered yes to any of these questions, you are potentially eligible for Medicaid.
Visit www.myflorida.com/accessflorida to complete a Medicaid application.

Include confirmation of a completed Medicaid application with the enclosed form or provide the information below if you have a pending application.

Application number ____________________

Date of application: ____________________

The enclosed form is for consideration of the hospital charges only, and does not address any physician or ancillary charges.

If you have any questions please contact the Financial Assistance Department at 1(855)-233-1555.

Mailing address: BayCare Health System
Central Business Office/Financial Assistance
PO BOX 2369
Oldsmar, FL 34677-2110

WEB

Please complete all information and return this form to the Financial Assistance Department. We will review the information you have provided and determine if there are any programs to assist you with your hospital bill.

PATIENT INFORMATION

Account #______________ CPI #____________________

Name:______________________________________ Date of Birth: ___________ SS #: ________________________

Veteran: ☐ Yes ☐ No Marital Status: ☐ M ☐ S ☐ D ☐ W US Citizen or legal resident in the US: ☐ Yes ☐ No

Address:______________________________________ Mailing Address:______________________________________

______________________________________ ______________________________________

Home Phone:_____________ Cell Phone:_____________ Email Address: ______________________________________

FINANCIAL ASSISTANCE SCREENING **Please answer all questions with yes or no**

Is the patient PREGNANT or was the admission pregnancy related? ☐ Yes ☐ No
Is the patient a DEPENDENT CHILD? OR Does a DEPENDENT CHILD live with the patient? ☐ Yes ☐ No
Does the patient have a pending or approved MEDICAID application? ☐ Yes ☐ No
Is the patient legally DISABLED, BLIND or potentially DISABLED for 12 months? ☐ Yes ☐ No
Has the patient filed for any COUNTY, STATE or FEDERAL assistance during the past year? ☐ Yes ☐ No
Does the patient have PRIVATE HEALTH INSURANCE? ☐ Yes ☐ No
Is the patient a VICTIM OF CRIME? ☐ Yes ☐ No

HOUSEHOLD INFORMATION Complete for all people living in the household regardless of relationship to the patient

List all household member names	Date of Birth	Social Security Number	Relationship to Patient	US Citizen

HOUSEHOLD INCOME include non-employment sources like Workman's or Unemployment Compensation, pensions, rental income, interest from investments, dividends, trust funds, child support, alimony, income from Social Security, Veteran's Administration or other benefit programs.

PLEASE PROVIDE INCOME INFORMATION FOR THE PAST 12 MONTHS
Adults living with a non spouse, please list only your income

	Income For	Income Source	Monthly Gross Income	Yearly Gross Income	Months of Income	Employer Name
Current						
Prior						
		Total:				

HOUSEHOLD EXPENSES

Expense Type	Monthly	Expense Type	Monthly	Expense Type	Monthly
Rent		Electric			
Mortgage		Phone			
Food		Gas			
Automobile(s)		Water			
Insurance		Sanitation			
Taxes		Other Utility			
				Totals	

HOUSEHOLD ASSETS

Bank Name	Account Type	Balance

Mortgage Holder	Balance	Approximate Value

Type of Vehicle	Primary (Y/N)	Balance	Approximate Value	Make / Model	Year

Other Asset Type/Other Mortgage Information	Balance	Approximate Value

If there is no income or limited income that does not meet monthly expenses, please explain: ________________________________

____

ADDITIONAL QUESTIONS:

Is your current illness/injury related in any way to an accident? ☐Yes/☐No. Date of accident: ______.Type of accident ___________.

Have you made a claim or retained an attorney to represent you in any manner arising out of the accident which caused you to seek treatment in the hospital ☐Yes/☐No If Yes, please explain: ____.

Have you received or do you anticipate receiving any money from any source including insurance companies for this accident?
☐Yes/☐No If Yes, how much? $__________________.

The Hospital reserves its right to change any decision made in reliance of this form, including the reversal of any write-offs or discounts, if the submitted information is inaccurate or false or if your medical bills relate to an accident for which there is a subsequent recovery of monies.

I certify that the information above is correct and understand that in accordance with FL Statute 817.50 providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree.

I further grant **BayCare Health System** authorization to verify any or all information given, and authorize a consumer credit report if needed to determine eligibility.

________________________________ ____________ ________________________________ _____________

Patient/Guarantor Signature **Date** **Witness Signature** **Date**

FORMS NOT WITNESSED OR INCOMPLETE WILL BE RETURNED, UNPROCESSED
Notary not required
This application is for consideration of the hospital charges only, and does not address any physician or ancillary charges.