ECD# _____

Date of Service: _____

CPI # _____
(office use only)

Financial Assistance Application

To apply for financial assistance for medical expenses incurred at BayCare Health System, please complete the attached application and return it to the Financial Assistance Department. It is very important to follow the instructions below in order for your application to be reviewed:

- List financial information for a full 12 months on the application.
- If the patient is a minor, list financial information for the parent or guardian.
- Applications must be signed AND witnessed on same date to be considered for assistance. Notary is not required.

This application does not address Non BayCare Medical Group physician charges. Completed applications received by the Financial Assistance Department will be reviewed to determine programs that may be able to assist. If additional information is needed, a representative will contact you.

SPECIAL NOTICE TO MEDICARE RECIPIENTS ONLY

Federal regulations require Medicare recipients to provide proof of income and assets when applying for financial 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, debit card 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?**
- **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.

Visit baycare.org/about-us/financial-assistance for answers to frequently asked questions or email us at finassist@baycare.org or reach the Financial Assistance Department by phone at 1(855) 233-1555.

Application can be emailed to finassist@baycare.org , faxed to (813) 635-7731 or mailed to BayCare Health System: Financial Assistance PO BOX 6120 Clearwater, FL 33758-6120

BayCare

ECD# _____

Date of Service: _____

CPI # _____
(office use only)

PATIENT Name: _____ Date of Birth: _____ US Citizen/Legal Resident ☐Yes ☐ No

Address: _____ Mailing Address: _____ Valid Visa: ☐Yes ☐ No Type_____

City, State, ZIP_____ City, State, ZIP _____ Phone: _____

Email: _____ Pregnant: ☐Yes ☐ No Disabled: ☐Yes ☐ No Marital Status: ☐ M ☐ S ☐ D ☐ W ☐ X*
*married, but separated, living apart

HOUSEHOLD INFORMATION Households are defined as spouses, parents of minors, minors and/or siblings under 21 living together

Household Members PLEASE INCLUDE PATIENT INFORMATION	Date of Birth	Last 4 digits of SS# Or Type of Valid Visa (Work, Visitor, Student, etc.)	US Citizen Legal Resident Y/N	Relationship to Patient	Tax Filing Status Choose Individual, Joint, Dependent, Not Filing
				Self/Patient	

HOUSEHOLD INCOME List all income/no income for household members listed above including patient.

Name of household member with or without income in the past 12 months, from date of application DO NOT WRITE N\A	Income Source- Do Not Write N/A Employer Name, Self-Employment, Odd Jobs, No Income, Workman's, Unemployment Compensation, pensions, rental income, trust funds, child support, alimony, Social Security, Veteran's Administration	Number of months with income	Number of months without income	Current Gross Monthly Income	Yearly Gross Income List total income for the past 12 months from date of application
Self/Patient					
	Total:				

Have you applied for any program listed below in the past 12 months:
Circle all that apply

Medicaid

Social Security Disability

County Medical Coverage

Workers Compensation

Health Insurance Marketplace

If you are claiming No Income, tell us who is supporting you _____

Is there health/auto insurance to cover any cost of your medical care? ☐Yes _____ ☐ No
Insurance/Policy#

ATTENTION MEDICARE RECIPIENTS: Federal regulations require Medicare recipients to provide proof of income and assets when applying for hospital assistance.

The Hospital reserves its right to change any decision made in reliance of this form, including the reversal of a write-off, if the submitted information is inaccurate/false or if 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 grant **BayCare Health System** authorization to verify information given through a consumer credit report if needed.

_____ _____ _____ _____
Patient/Guarantor Signature **Date** **Witness Signature** (Notary not required) **Date**

PATIENT AND WITNESS SIGNATURE MUST BE SAME DATE TO BE CONSIDERED A VALID APPLICATION