Financial Assistance Application

PARRISH MEDICAL CENTER

ACCOUNT NUMBER(S):
_____

PATIENT: _____ SS#:_____ Dependents/Adults In Household: _____

GUARANTOR: _____ SS#: _____

SPOUSE: _____ SS#: _____ Yearly Gross Income $ _____

ADDRESS: _____ PHONE#_____

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Have you applied for Medicaid, Medically Needy, or other State/Federal Assistance? ☐ Yes ☐ No.

Are you pregnant? ☐Yes ☐No Do you have minor children? ☐ Yes ☐ No. Are you disabled or receiving SSDI? ☐ Yes ☐No.

Does applicant qualify for Medicaid? ☐ Yes ☐ No. Does applicant qualify for any other state or Federal Programs ☐ Yes ☐No

List programs applicant may qualify for: _____ Patient / Applicant **does not** qualify for Medicaid: _____

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Dependents/Adults In Household For additional dependents please add

	Name	Relationship	Age	Date of Birth
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

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Place of Employment: (Guarantor) _____ Phone: _____

Place of Employment: (Spouse) _____ Phone: _____

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Monthly Income

Are you self-employed or own your own business? ☐ Yes ☐No If yes please provide financial statements with application.

Employment: Guarantor: _____
Employment _____
Social Security _____
Veteran Administration _____
Unemployment _____

Child Support _____
Rentals _____
Real Estate _____
Other _____
Work Comp _____

Total Monthly Income: _____

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Monthly Expenses

Rent _____
1st Mortgage _____
2nd Mortgage _____
Electric Gas _____
Child Care _____
Health Insurance _____
Medical Bills _____
Credit Cards _____

1st Car Payment _____
2nd Car Payment _____
Car insurance _____
Water _____
Telephone _____
Cable T.V. _____
Internet _____
Food _____

Adjusted Monthly Income: _____ **Total Monthly Expenses:** _____

LIQUID ASSETS

Name Of Bank/Credit Union	_____	Balances	_____
Savings Account	_____	Balances	_____
Checking Account	_____	Balances	_____
Other	_____	Balances	_____
Other	_____	Balances	_____

TOTAL LIQUID ASSETS $ _____

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NON-LIQUID ASSETS

Real Estate	_____	Stocks	_____
2nd Automobile	_____	Bonds	_____
Boat	_____	CD's	_____
Life Insurance	_____	Other	_____
Loans	_____	Other	_____
** Value of 1st Automobile	_____	** Value of Homestead	_____

TOTAL NON-LIQUID ASSETS $ _____ **TOTAL ASSETS** $ _____

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Letter of Support: **By signing this letter of support, this in no way obligates you for the patient's bills.**

I, _____ provide room and board and/or financial assistance for _____

_____. Signed by: _____

Relationship_____ Date _____

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********** **Proof Of Income Must Accompany This Application** **********

I _____ certify that my family income for the past 12 months has been $ _____ and can be verified by contacting the following employer(s):

Company: _____ Phone: _____

Company: _____ Phone: _____

I hearby authorize Parrish Medical Center to verify the information on this application by whatever means necessary. I further understand that this could mean contacting my employer, my bank or running a credit report.

I understand that to be eligible for this program, I must be willing to apply for any and all State and Federal programs or private sources available to pay this bill. I also understand that this application can be re-evaluated at any time if Parrish Medical Center finds it necessary.

I further certify the foregoing information given by me on this application is true and accurate in accordance with 817.50 of public law 79-725, providing information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree. Should any changes occur as to the information given by me on the application, I agree to promptly notify Parrish Medical Center.

SIGNATURE OF PATIENT AND/OR GUARANTOR: _____ Date: _____

SPOUSE SIGNATURE: _____ Date: _____

WITNESSED BY: _____ Date: _____