We are providing an application because you may qualify for our Financial Assistance Program. **In order to be considered for full assistance, you must complete, sign and provide all supporting documentation required from the attached Financial Assistance Application.**

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested. If you fail to provide all the necessary information, your application for Financial Assistance will be denied.

Please read the form carefully as it provides critical information for your approval in our Financial Assistance Program. Any missing or incomplete information will cause your application to be denied, or your approval to be delayed! Please be advised that both signatures, patient/guarantor and witness, are required for your application to be considered for approval.

As you may be aware, the Affordable Care Act went into effect on October 1, 2013. The Act provides all Americans the opportunity to have access to quality, affordable coverage. The Affordable Care Act intends to provide Americans with options and alternatives for health care coverage. Health Insurance Exchanges will provide a marketplace to assist people in choosing options for coverage that may be subsidized through tax credits for many Americans.

If you are interested in what is available, go to the Healthcare.gov website that will allow you to enroll as well as provide some helpful FAQs on the Affordable Care Act.

This program applies to services rendered by the UF Health St Johns.

Please allow 7 business days for our review process. We will notify you of our determination of qualification by letter. If you have any questions pertaining to this application, please contact one of our representatives at the numbers listed below.

Sincerely,

UF Health St Johns
Patient Financial Services Department

******************************Financial Assistance Application******************************

UF Health St Johns
Patient Financial Services
400 Health Park Blvd
St Augustine, FL 32086

Patient Name:
MRN:
Patient DOB:
Guarantor: Address:
Visit Number:

DEPENDENTS IN FAMILY*

(This includes spouse, children under 18 and all others claimed on your and/your spouse's tax return)

Name:(first,middle,last)	DOB:	Name:(first,middle,last)	DOB:
1. ____________________	______	4. ____________________	_______
2. ____________________	______	5. ____________________	_______
3. ____________________	______	6. ____________________	_______

*********************PATIENT/GUARANTOR INFORMATION********************

Social Security#:_______________________Employer Name:____________________________

Do you have insurance?_________If yes, please provide insurance information:_______________________________

Hourly Pay Rate: $_____________Average Hours Work Per Week:________Current Gross Weekly, Monthly or Yearly Income: $_________________

If Unemployed, last date worked:_____/___/___

Marital Status (circle one): Single / Married / Divorced / Separated

****Florida does not offer legal separation. Therefore additional documentation will be requested if this status is selected****

************************SPOUSE INFORMATION************************************

Social Security#:_______________________Employer Name:____________________________

Hourly Pay Rate: $_____________ Average Hours Work Per Week:______________Current Gross Weekly, Monthly or Yearly Income:$_________________

If Unemployed, last date worked:_____/___/___

Does the spouse have insurance?_________If yes, please provide insurance information:_______________________________

********************************OTHER INCOME***

Please provide supporting documentation for any of the below mentioned items if applicable.

	Patient/Guarantor	Spouse	Dependent(s)
Social Security	$____________	$____________	$_____________
Pension	$____________	$____________	$_____________
Unemployment	$____________	$____________	$_____________
Worker's Compensation	$____________	$____________	$_____________
VA Benefits	$____________	$____________	$_____________
Child Support	$____________	$____________	$_____________
Alimony	$____________	$____________	$_____________
Rental Income	$____________	$____________	$_____________

***************************************ASSET INFORMATION***********************************

Please provide supporting documentation for any of the below mentioned items if applicable.

	Patient/Guarantor	Spouse
Home Value	$________________	$_____________
Balanced Owed	$________________	$_____________
Other Real Property Value/Assets	$________________	$_____________
Stocks/Bonds/CDs/IRAs	$________________	$_____________
Bank Account: Checking	$________________	$_____________
Bank Account: Saving	$________________	$_____________

Have you applied for Medicaid or other assistance? Yes/No
If yes and approved please provide your Medicaid number__________________.
If yes and you have been denied please provide a copy of the denial letter.
If yes and pending application process please provide application#______________.
If no, please contact your local Medicaid office to determine eligibility.

I certify that the above information is true and accurate. Futhermore, I authorize UF Health to make any inquiries or obtain any information necessary to verify the accuracy of the information contained herein including my employer, the Credit Bureau,my creditors or other financial institution if deemed necessary. In accordance with public law s.817.50 F.S.,providing false information to defraud a hospital for the purpose of obtaining goods or service is a misdemeanor in the second (2nd) degree.

Signature:____ Date:_________________

SUPPORTING DOCUMENTATION CHECKLIST

When applying for financial assistance, please provide complete documentation. If there is a failure to provide adequate documentation assistance may not be extended

.

☐ **EMPLOYMENT—**Please provide verification of all household incomes for the last three (3) months (if employed with the same employer since January 1st of the current year the most recent check stub with YTD Gross Income will suffice) A signed letter of wage verification from your employer(s) is also acceptable

☐ **LETTER OF UNEMPLOYEMENT**—If any adult member of the household is unemployed, please provide a letter from **someone outside of the home** stating the length of unemployment.

☐ **LETTER OF SUPPORT—** Please provide a letter from anyone assisting you in meeting your financial needs. This letter must show how assistance is given, in what amounts, and how often. Example: I have given John Doe food and shelter from 01/01/2018 through 03/01/2018.

☐ **SELF EMPLOYED --** Provide a balance sheet and your profit & loss statement for the last 3 months **(do not include personal expenses), and 3-months bank statements (all business and personal accounts)**

☐ **BANKING ACCOUNTS—**Provide complete copies of bank statements for one month for all accounts (**checking, savings, investments, and/or other bank accounts not listed**)

☐ **SOCIAL SECURITY/SSI--**Provide a copy of your letter from Social Security stating amount received monthly **(Must be current year's benefit letter)**

☐ **VA--**Provide a copy of your award letter from the Veterans Administration. (**Must be current year's benefit letter**)

☐ **PENSION/RETIREMENT/DIVIDENDS/INTEREST--**Provide a copy of your award letter stating the amount you will receive or copies of your check. (**Must be current income**)

☐ **WORKER'S COMPENSATION--**Provide either the award letter detailing your Worker's Compensation benefit allocation and distribution and/or a letter from your assigned adjuster at the Worker's Compensation office.

☐ **UNEMPLOYMENT COMPENSATION--**Provide a copy of your award letter.

☐ **CHILD SUPPORT/ALIMONY --** Provide a copy of your Divorce Decree/Custody Agreement which states the amount paid and how often or proof of distribution through the Department of Revenue State Disbursement Unit.

☐ **COLLEGE LOANS, GRANTS AND/OR SCHOLARSHIPS--**Provide a copy of loan, grant and/or scholarship award notifications.

☐ **UNUSUAL INCOMES--MORTGAGES, RENTAL PROPERTIES, INSURANCE BENEFITS, ETC. --** Provide copies of the actual documents showing the amounts received.

*** **Please note: If you are applying for Assistance for balances with UF Health in relation to an Automobile Accident** ***

You will need to provide your automobile insurance information to UF Health Customer Service. We cannot process your request for financial assistance until all available insurance either pays or denies your bill. Even though collection of your unpaid hospital accounts may be suspended, UF Health Hospital remains entitled to payment of your hospital bills from settlements with those who caused your injuries. If an accident attorney represents you, you also must inform UF Health Patient Financial Services Department of your attorney's name, address and telephone number

If you have any questions regarding your application for financial assistance, please call 904-819-4539 or 844-223-5849.