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_____