PATIENT ATTESTATION AND APPLICATION FOR FLAGLER HOSPITAL CHARITY

Patient Name: ____ **Date:** ________________

ATTESTATION:

1. I attest that I have no income. Initials of Patient or Responsible Party: ______________________
2. I attest that I have no assets. Initials of Patient or Responsible Party: ______________________
3. **A.** I attest that I am homeless and have been since: **Date:** ________ **B.** I attest that I am homeless and have no identification since: **Date:** _________ **C.** My Last known address was: ____________________
   Initials of Patient or Responsible Party: ______________________
4. I attest that I have no insurance to cover my hospital services. Initials of Patient or Responsible Party: _________
5. Do you or your spouse own property in which you do not reside? **Yes**: __________ **No:** ___________
   If yes, please provide the property address: ______________________
   Initials of Patient or Responsible Party: ______________________

FAMILY INCOME	MEMBERS OF FAMILY (# of Persons)	(LAST 12MONTH INCOME) SALARY BEFORE TAXES	OTHER INCOME
Single Individual	____________	____________	____________
Spouse	____________	____________	____________
Children (under 18 or full-time student)	____________	____________	____________
Other dependents allowed for income tax purposes	____________	____________	____________
Total Family Size	____________	**Total Gross Income**	$____________

I certify that the above information is true and accurate to the best of my knowledge. Furthermore, I will make an application for any assistance (Medicaid, Medicare, insurance, etc.) which may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for my hospital charges.

I understand that this application is made for the hospital to judge my eligibility to have my hospital account covered by the Flagler Hospital Charity Write-Off, by the criteria established and which is on file at the hospital. I understand that the hospital may verify any of the above information, and I grant permission for such verification and agree to assist in any way requested. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial ability again and take whatever action deemed appropriate.

In accordance with **Public Law 79-725, s.817.50**, providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor in the second degree.

______________________________	______________________________
Person Making Request (Signature)	Witness (Signature)
______________________________	______________________________
Person Making Request (Print)	Witness (Print)
______________________________	______________________________
Date	County of Residence

Patient's Name: ______________________ Admission Date: __________ Discharge Date: __________

Account #:________ Balance: $________ FPG Score:_____ ______________________________

Management Approval/Date