Baptist Health South Florida

BAPTIST HOSPITAL OF MIAMI • SOUTH MIAMI HOSPITAL • DOCTORS HOSPITAL
BAPTIST CHILDREN'S HOSPITAL • HOMESTEAD HOSPITAL • MARINERS HOSPITAL
BAPTIST OUTPATIENT SERVICES • BAPTIST CARDIAC & VASCULAR INSTITUTE

NOTICE TO APPLICANTS: ALL FEDERAL, STATE AND LOCAL RESOURCES SUPERSEDE THIS PROGRAM

Financial Evaluation & Request for Financial Assistance

Name of Patient ______________________ Previous Married Name(s) ______________________

If patient is a minor, complete this Financial Evaluation on Parents/Guardian: Name(s) ______________________

Address ______________________ Zip __________ Phone ______________________

How long have you lived at this address? ______________________
(If less than 1 year, give previous address)

Birthdate ______________ Birthplace ______________ Number of Dependents ______________

Marital Status ______ Nearest Relative/Guardian ______________________ Relationship ______________

Phone ______________ Address ______________________ Zip __________

Health care services covered by application: ______Inpatient ______Outpatient

If inpatient, please provide dates of hospitalization: ______________________

If outpatient, please briefly describe (e.g. emergency department, MRI, Mammogram, endoscopy) requested service: ______________________

____

Members of Household:

Name	Relationship	Birthdate	Occupation	Employer's Address	Salary
#1					$
#2					$
#3					$
#4					$
#5					$
#6					$

Financial Resources

Section 1 - INCOME: Patient Occupation ______________________

Name & Address of Employer ______________________

______________________ Gross Salary $ ______________

Years of Employment ______________________
(If less than 1 year, list previous Employer)

Spouse Occupation ______________________ Gross Salary $ ______________

Years of Employment ______________________
(If less than 1 year, list previous Employer)

Other Types of Income:

Supplemental Security Income	$________	Vet. Pension	$________	Unemployment Compensation	$________
Old Age Assistance	$________	Social Security	$________	Interest Income	$________
Aid to Disabled	$________	Social Security-Disabled	$________	Stocks/Bonds	$________
Investments	$________	Rental (Income)	$________	Dividends	$________
Aid to Dependent Children	$________	Aid to Blind	$________	Certificates of Deposit	$________
Dade County Public Assistance	$________	Alimony	$________	Other (Specify)	$________
Pension	$________	Child Support	$________		
		Workers' Compensation	$________	**TOTAL**	**$________**

S.S. # ______________ V.A. Serial # ______________ Medicaid I.D. # ______________

Section 2 - PROPERTY: Homestead-Current Assessed Value $ ______________ Unpaid Balance $ ______________

Mortgage Company ______________________ Monthly Payment $ ______________

Other Property (such as condominium, townhouse, second home, land holdings, income producing property): ______________

Current Assessed Value $ ______________ Unpaid Balance $ ______________ Monthly Payment $ ______________

Section 3 - SAVINGS:

SAVINGS: Bank ______________ Account # ______________ Balance $ ______________

CHECKING: Bank ______________ Account # ______________ Balance $ ______________

CREDIT UNION: Bank ______________ Account # ______________ Balance $ ______________

Over ▶

Financial Evaluation & Request for Financial Assistance

Section 4 - WAS HOSPITALIZATION THE RESULT OF AN ACCIDENT: ☐ Yes ☐ No

If Yes, do you have an Attorney? ☐ Yes ☐ No If Yes, Attorney's Name ____________________

Address ____________________ Zip __________

Phone ____________________

Section 5 - AUTOMOBILE:

Make __________ Model ____________________ Year __________

Value $ ____________________ Unpaid Balance $____________________

Insurance Company ____________________ Policy #____________________

Section 6 - OTHER PERSONAL PROPERTY: (Such as other motor vehicles, boats, business equipment).

List showing current value and any unpaid loan amount: ____________________

____

Section 7 - INSURANCE:

Hospitalization __________ Policy #__________ Group #__________

Supplemental Hospitalization __________ Life Insurance Co.__________

Face Value $__________ Beneficiary__________ Sick & Accident __________

Section 8 - MONTHLY EXPENDITURES: (Include Installment Payments)

Mortgage/Rent	$__________	Property Taxes	$__________
Telephone	$__________	Lights	$__________
Food	$__________	Other Utilities	$__________
Auto Insurance	$__________	Clothing	$__________
Medical Premiums	$__________	Auto Expenses (Gas, etc.)	$__________
Medications	$__________	Miscellaneous Expenses (Specify)	$__________

Section 9 - LIST ANY OTHER OUTSTANDING DEBTS: (Credit Cards, Loans, Hospital/Doctor Bills, Etc.)

Company	Balance Owed	Monthly Payment
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$

Total Expenses $ ____________________ Total Income $____________________

In consideration of Baptist Health South Florida's reliance on the representations made herein, the undersigned agree that in the event of any material omission, misstatement or misrepresantation concerning any of the information requested by or provided in this statement, they shall be jointly and severally liable for the charges for all goods, services and treatments furnished the patient by Baptist Health South Florida, or its affiliated entities, whether or not such charges are charged off or otherwise treated as charity, welfare or bad debt, and further agree that they shall be jointly and severally liable for attorney's fees and costs incurred by Baptist Health South Florida, in the enforcement of the agreement.

NOTICE

The undersigned acknowledge that Section 817.50, Florida Statutes, provides that whoever shall, willfully and with intent to defraud, obtain or attempt to obtain goods, products, merchandise or services from any hospital in this state shall be guilty of misdemeanor of the second degree.

____
SIGNATURE DATE

____
SIGNATURE OTHER THAN PATIENT (STATE RELATIONSHIP) DATE

____
WITNESS DATE
SIGNATURE MUST BE WITNESSED