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

UF Health
Customer Service
P O Box 100334
Gainesville, Fl 32610-0334

Patient Name:
MRN:
Patient DOB:
Guarantor: Address:
Account 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:_________________