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](https://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 Gainesville.**

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
Customer Service Department
Phone: (352) 265-7906 or (888) 766-8154
Fax: (352) 627-4401
Financial Assistance Application

Patient Name: ________________________ Guarantor: ________________________
Patient DOB: ________________________ Address: ____________________________

DEPENDENTS IN FAMILY
(This includes spouse, children under 18 and all others claimed on your and/or your spouse’s tax return)
Name: ________________________ DOB: ________________________
1. ________________________ 4. ________________________
2. ________________________ 5. ________________________
3. ________________________ 6. ________________________

PATIENT/GUARANTOR INFORMATION
Social Security #: ________________________ Employer Name: ________________________
Hourly Pay Rate: $ __________ Average Hours Worked Per Week: _______
Current Gross Weekly, Monthly or Yearly income: $ __________
If Unemployed, last date worked: __/__/____

SPOUSE INFORMATION
Social Security #: ________________________ Employer Name: ________________________
Hourly Pay Rate: $ __________ Average Hours Worked Per Week: _______
Current Gross Weekly, Monthly or Yearly income: $ __________
If Unemployed, last date worked: __/__/____

OTHER INCOME
Patient/Guarantor Spouse Dependent(s)
Social Security $ __________ $ __________ $ __________
Pension $ __________ $ __________ $ __________
Unemployment $ __________ $ __________ $ __________
Worker’s Compensation $ __________ $ __________ $ __________
VA Benefits $ __________ $ __________ $ __________
Child Support $ __________ $ __________ $ __________
Alimony $ __________ $ __________ $ __________
Rental Income $ __________ $ __________ $ __________

ASSET INFORMATION
Patient/Guarantor Spouse
Home Value $ __________ $ __________
Balance Owed $ __________ $ __________
Other Real Property Value $ __________ $ __________
Stocks/ Bonds $ __________ $ __________
Other Assets (Boat, Motor Home, Etc) $ __________ $ __________
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 please provide application # ________________________
If no, please contact your local Medicaid office to determine eligibility.

I certify that the above information is true and accurate. Furthermore, I authorize the 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: ____________ Witness: ______________________

Both signatures are required or your application will be denied.