

APPLICATION FOR FINANCIAL ASSISTANCE



____ Please initial and read before signing. All information obtained will be utilized by our Patient Accounts staff to help resolve your financial obligation to St. Vincent's HealthCare. All questions asked and information requested will be utilized to determine eligibility for potential funding sources such as Medicaid, HCRA, etc. and remain confidential. I CERTIFY I am uninsured or underinsured and the information I have provided is true and accurate to the best of my knowledge. I will make application for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay this hospital bill and will take all action necessary to obtain assistance from the above sources.

____ I understand that if I do not cooperate with St. Vincent's HealthCare (Herein known as SVHC) within 45 days from the date of service in requesting ANY additional information, my application may be denied for possible financial assistance. I hereby designate SVHC's Patient Accounts Department as my representative to act on my behalf and assist in the application process and/or appeal of my application for any medical assistance program.

____ I authorize a representative from SVHC Patient Accounts to file an application which includes my electronic signature, receive any and all information from the Department of Children and Families regarding the status, disposition, eligibility or denial of my application for medical assistance and to file a Fair Hearing Appeal against the Department of Children and Families if a disagreement arises with the disposition of the application. I also grant permission for a Patient Accounts representative to assist in obtaining a certified copy of a birth or death certificate for myself or a member of my immediate family in order to continue the application process. A copy of the designation of representative shall remain in effect for one (1) year or until otherwise advised by the SVHC Accounts Department or myself. I acknowledge receipt of Rights and Responsibilities, if applicable.

____ I will ASSIGN to SVHC ALL FUNDS received from the above sources, which are provided to help with the HOSPITAL BILL. I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s), counselor(s) (including clergy) and attorney(s), agree to hold and maintain in strict confidence any written communications and/or oral discussions between me and SVHC, regarding matters relating to services provided to me by SVHC.

____ I understand that the information which I submit is subject to verification by SVHC, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I AUTHORIZE my employer to release to SVHC proof of my income. I UNDERSTAND that if any information I have given proves to be untrue, SVHC will re-evaluate my financial status and take whatever action becomes appropriate.

____ I hereby certify that the above information is true and correct to the best of my knowledge. In accordance with s.817.50 F.S., providing false information to defraud a hospital for goods and services is a misdemeanor in the second (2nd) degree. St. Vincent's HealthCare can require income tax information or investigate wages with employer to validate eligibility.

Patient: _____

Date: _____

Guarantor: _____

Date: _____

Hospital Representative: _____

Date: _____