



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/Guardians: Name(s) \_\_\_\_\_

Address \_\_\_\_\_ City and Zip \_\_\_\_\_ Phone \_\_\_\_\_

How long have you lived at this address? \_\_\_\_\_  
*(If less than one year, give previous address)*

Birthdate \_\_\_\_\_ Birthplace \_\_\_\_\_ Number of Dependents \_\_\_\_\_

Marital Status \_\_\_\_\_ Nearest Relative/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_ Zip \_\_\_\_\_

Healthcare services covered by application:  Inpatient  Outpatient If inpatient, provide dates of hospitalization: \_\_\_\_\_

If outpatient, please briefly describe (e.g., emergency department, MRI, mammogram, endoscopy) service requested: \_\_\_\_\_

## Members of Household:

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

## Financial Resources

**Section 1 - INCOME:** Patient's Occupation \_\_\_\_\_

Name & Address of Employer \_\_\_\_\_

Gross Salary \$ \_\_\_\_\_

Years of Employment \_\_\_\_\_  
*(If less than one year, list previous employer)*

Spouse's Occupation \_\_\_\_\_ Gross Salary \$ \_\_\_\_\_

Years of Employment \_\_\_\_\_  
*(If less than one year, list previous employer)*

<b>Other Types of Income:</b>	Vet. Pension	\$ _____	Unemployment Compensation	\$ _____
Supplemental Security Income	Social Security	\$ _____	Interest Income	\$ _____
Old-age Assistance	Social Security-Disabled	\$ _____	Stocks/Bonds	\$ _____
Aid to Disabled	Rental (Income)	\$ _____	Dividends	\$ _____
Investments	Aid to Blind	\$ _____	Certificates of Deposit	\$ _____
Aid to Dependent Children	Alimony	\$ _____	Other (Specify)	\$ _____
Dade County Public Assistance	Child Support	\$ _____		
Pension	Workers' Compensation	\$ _____	<b>TOTAL</b>	<b>\$ _____</b>

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 \$ \_\_\_\_\_

# Financial Evaluation & Request for Financial Assistance

## Section 4 - ARE THESE HEALTHCARE SERVICES 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 \_\_\_\_\_ Sickness & 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 \$ \_\_\_\_\_

## NOTICE

The undersigned represent that the applicant has no health insurance or any other payor source (e.g., third party auto insurance, workers' compensation, etc.) for the healthcare services for which this application is being completed. The undersigned also represent that the information provided in this application is true and correct in all material respects.

Each of the undersigned authorizes Doctors Hospital and its agents and affiliates to obtain a credit report from a consumer reporting agency for purposes of verifying the information provided by the undersigned and for determining eligibility for financial assistance.

In consideration of Doctors Hospital's reliance on the representations made herein, the undersigned agree that in the event of any material omission, misstatement or misrepresentation 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 Doctors Hospital, 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 attorneys' fees and costs incurred by Doctors Hospital, in the enforcement of the agreement.

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