Bethesda Hospital
BAPTIST HEALTH SOUTH FLORIDA

Caseworker: _____
Patient #: _____
Newborn #: _____
M/R #: _____

Application for: Medicaid - Disability - Charity

Language: English - Spanish - Creole- Other _____

Patient legal status: Citizen - Naturalized Citizen - Perm. Resident - Work Permit - Illegal - Sponsored

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)

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 - 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 Baptist 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 Baptist 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 Baptist 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 Baptist 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