ECD# _____

Date of Service: _____

CPI # _____
(office use only)

Financial Assistance Application

To apply for financial assistance for medical expenses incurred at BayCare Health System, complete the attached application. The Financial Assistance Department will review completed applications and determine which program you may qualify for. If additional information is needed, a representative may contact you. This application is for consideration of the hospital and hospital employed physicians' charges only and does not assist with other non-BayCare Medical Group charges. For your application to be processed timely please make sure to,

- List income source for all household members for a full 12 months. If the patient is a minor, list financial information for the parent or guardian.
- List asset information for all household members.
- Print application to sign and date.

SPECIAL NOTICE TO MEDICARE RECIPIENTS ONLY	POTENTIAL MEDICAID PARTICIPANTS
Federal regulations require Medicare recipients to provide proof of income and assets when applying for financial assistance. **Required proofs:** • **Proof of Income: copy of notices from Social Security, Unemployment Compensation, pensions, rental income or ANY income used to pay your expenses** • **No Income: provide a letter of support from the individual assisting you** • **Proof of Assets: current bank statement, debit card statement, value of IRA, stocks, bonds, 401k's, whole life insurance policy cash value, and real estate (other than homestead)**	• **Are you pregnant OR have a child aged 17 or under in your custody?** • **Are you between the ages of 18-21?** • **Are you over 65 years of age?** • **Are you receiving Social Security disability?** **If you answered yes to any of these questions, you are potentially eligible for Medicaid. Visit www.myflorida.com/accessflorida to complete a Medicaid application.**

Visit baycare.org/about-us/financial-assistance for answers to frequently asked questions or email us at finassist@baycare.org or reach the Financial Assistance Department by phone at 1(855) 233-1555.

Email completed applications to finassist@baycare.org, by fax to (813) 635-7731 or by mail to BayCare Health System: Financial Assistance, PO BOX 6120 Clearwater, FL 33758-6120.

ATTENTION: Sending unencrypted email is not a secure method of sending protected health information (PHI). The information you sent, unless encrypted, could be electronically captured during transmission.

BayCare

ECD# _____

CPI # _____
(office use only)

Complete applications received by the Financial Assistance Department will be reviewed to determine programs that may assist you with your hospital bill. This application is for consideration of the hospital charges only and does not assist with physician charges.

PATIENT NAME: _____ **Date of Birth:** _____

Living Address: _____ **City**_____ **State** _____ **Zip** _____

Mailing Address: _____ **City**_____ **State** _____ **Zip** _____

Email: _____ **Phone:** _____

FINANCIAL ASSISTANCE SCREENING

Is the patient PREGNANT or was the admission pregnancy related?	☐ **Yes**	☐ **No**
Is the patient a DEPENDENT CHILD? OR Does a DEPENDENT CHILD live in the home?	☐ **Yes**	☐ **No**
Is the patient legally DISABLED, BLIND or potentially DISABLED for 12 months?	☐ **Yes**	☐ **No**
Is the patient a VICTIM OF CRIME?	☐ **Yes**	☐ **No**
Does the patient have HEALTH INSURANCE?	☐ **Yes**	☐ **No**
I give permission to leave Department name with case status on my voicemail.	☐ **Yes**	☐ **No**
I give permission to receive email communication from Financial Assistance?	☐ **Yes**	☐ **No**

HOUSEHOLD INFORMATION *Households are defined as spouses, parents of minors, minors and/or siblings under 21 living together.*

List all household member names	Date of Birth	Gender	Marital Status	Relationship to Guarantor	US Citizen /Legal Resident	Previous BayCare account? Y/N
Patient						

HOUSEHOLD INCOME *List 12 months of income/no income for household members listed above including patient.*

	Name of household member with or without income in the past 12 months	Income Source Wages, Self-Employment, Odd Jobs, No Income, Workman's or Unemployment Compensation, pensions, rental income, trust funds, child support, alimony, Social Security, Veteran's Administration	Employer Name	Current Monthly Gross Income	Yearly Gross Income List total income for the past 12 months	Months of Income/No Income
Current						
Prior						
			Total:			

HOUSEHOLD ASSETS

Bank Name	Account Type	Balance

Mortgage Holder	Balance	Approximate Value

Type of Vehicle	Primary (Y/N)	Balance	Approximate Value	Make / Model	Year

Other Asset Type (401K, IRA, Stocks, Bonds, CD)	Total Approximate Value

ADDITIONAL QUESTIONS:

If you are claiming No Income, tell us who is supporting you:

_____

Are you receiving food stamp benefits? ☐Yes ☐No. Amount: _____.

Is your current illness/injury related in any way to an accident? ☐Yes ☐No. Date of accident: _____Type of accident _____.

ATTENTION MEDICARE RECIPIENTS

Federal regulations require Medicare recipients to provide proof of income and assets when applying for hospital assistance.
If you are claiming No Assets, please check here ☐.

The Hospital reserves its right to change any decision made in reliance of this form, including the reversal of a write-off, if the submitted information is inaccurate/false or if medical bills relate to an accident for which there is a subsequent recovery of monies. I certify that the information above is correct and understand that in accordance with FL Statute 817.50 providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree. I grant **BayCare Health System** authorization to verify information given through a consumer credit report if needed**.**

_____ _____

Patient/Guarantor Signature **Date**

FORMS NOT SIGNED OR INCOMPLETE WILL BE RETURNED, UNPROCESSED
For more information on the BayCare Financial Assistance Policy visit baycarefinancialassistance.org