Financial Assistance Application

To apply for financial assistance for medical expenses incurred at BayCare Health System, please complete the attached application and return it to the Financial Assistance Department. It is very important to follow the instructions below in order for your application to be reviewed:

- List financial information for a full 12 months on the application.
- If the patient is a minor, list financial information for the parent or guardian.
- Applications must be signed AND witnessed on same date to be considered for assistance. Notary is not required.

This application does not address Non BayCare Medical Group physician charges. Completed applications received by the Financial Assistance Department will be reviewed to determine programs that may be able to assist. If additional information is needed, a representative will contact you.

SPECIAL NOTICE TO MEDICARE RECIPIENTS ONLY

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)

POTENTIAL MEDICAID PARTICIPANTS

- 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.

Application can be emailed to finassist@baycare.org, faxed to (813) 635-7731 or mailed to BayCare Health System: Financial Assistance PO BOX 6120 Clearwater, FL 33758-6120

ECD# ______________________
Date of Service: ______________________
CPI # ____________________

(office use only)
## PATIENT INFORMATION

### Patient Name: ________________________  Date of Birth: ____________  US Citizen/Legal Resident [ ] Yes [ ] No

### Address: ____________________________  Mailing Address: ____________________________  Valid Visa: [ ] Yes [ ] No Type __________

### City, State, ZIP ____________________________  City, State, ZIP ____________________________  Phone: ____________________________

### Email: ____________________________  Pregnant: [ ] Yes [ ] No  Disabled: [ ] Yes [ ] No  Marital Status: [ ] M [ ] S [ ] D [ ] W

### HOUSEHOLD INFORMATION

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

<table>
<thead>
<tr>
<th>Household Members</th>
<th>Date of Birth</th>
<th>Last 4 digits of SS# Or Type of Valid Visa (Work, Visitor, Student, etc.)</th>
<th>US Citizen/Legal Resident Y/N</th>
<th>Relationship to Patient</th>
<th>Tax Filing Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self/Patient</td>
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<td>Not Filing</td>
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### HOUSEHOLD INCOME

List all income/no income for household members listed above including patient.

<table>
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<tr>
<th>Name of household member with or without income in the past 12 months</th>
<th>Income Source- Do Not Write N/A</th>
<th>Number of Months with Income/No Income</th>
<th>Current Gross Monthly Income</th>
<th>Yearly Gross Income</th>
<th>Have you applied for any program listed below in the past 12 months:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self/Patient</td>
<td>Employer Name, Self-Employment, Odd Jobs, No Income, Workman’s, Unemployment Compensation, pensions, rental income, trust funds, child support, alimony, Social Security, Veteran’s Administration</td>
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<td></td>
<td></td>
<td>Medicaid, Social Security Disability, County Medical Coverage, Workers Compensation, Health Insurance Marketplace</td>
</tr>
</tbody>
</table>

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

Is there health/auto insurance to cover any cost of your medical care? [ ] Yes [ ] No  Insurance/Policy# __________

### ATTENTION MEDICARE RECIPIENTS: Federal regulations require Medicare recipients to provide proof of income and assets when applying for hospital assistance.

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 ____________  Witness Signature ________________________  (Notary not required)  Date ____________

PATIENT AND WITNESS SIGNATURE MUST BE SAME DATE TO BE CONSIDERED A VALID APPLICATION