



Financial Assistance Application

ECD# _____
Date of Service: _____
CPI # _____ <small>(office use only)</small>

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.

<p align="center"><u>SPECIAL NOTICE TO MEDICARE RECIPIENTS ONLY</u></p> <p>Federal regulations require Medicare recipients to provide <u>proof of income and assets</u> when applying for financial assistance.</p> <p>Required proofs:</p> <ul style="list-style-type: none"> • <u>Proof of Income:</u> copy of notices from Social Security, Unemployment Compensation, pensions, rental income or ANY income used to pay your expenses • <u>No Income:</u> provide a letter of support from the individual assisting you • <u>Proof of Assets:</u> 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) 	<p align="center"><u>POTENTIAL MEDICAID PARTICIPANTS</u></p> <ul style="list-style-type: none"> • 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? <p>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.</p>
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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.

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.



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:** _____ **US Citizen or legal resident** Yes No

Address: _____ **Mailing Address:** _____ **Email:** _____

City, State, Zip _____ **City, State, Zip** _____ **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 with the patient? Yes No
- Is the patient legally DISABLED, BLIND or potentially DISABLED for 12 months? Yes No
- Is the patient enrolled in a County Medical Program? Yes No
- Is the patient a VICTIM OF CRIME? Yes No
- Does the patient have PRIVATE HEALTH INSURANCE? Yes No
- Has the patient applied for the Health Insurance Marketplace? Yes No
- I give permission to leave Department name with case status on my voicemail? 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

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 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	Current Monthly Gross Income	Yearly Gross Income List total income for the past 12 months	Months of Income	Employer Name
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)	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

Witness Signature

Date

FORMS NOT WITNESSED OR INCOMPLETE WILL BE RETURNED, UNPROCESSED
This application is for consideration of the hospital charges only, and does not address any physician or ancillary charges.