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ECD#
Date of Service:
CPI #(office use only)

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 <u>proof of income and assets</u> when applying for financial assistance.

Required proofs:

- <u>Proof of Income:</u> 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 <u>baycare.org/about-us/financial-assistance</u> for answers to frequently asked questions or email us at <u>finassist@baycare.org</u> 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 send, unless encrypted, could be electronically captured during transmission.



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PATIENT Name:		Date of Birth:						_ US Citizen/Legal Resident ☐Yes ☐ No			
Address:	Mailing Address:				Valid Visa: ☐Yes ☐ No T				Туре		
City, State, ZIP	City, State, ZIP							Phone:			
Email:	Pre			Disabled:					□s □ D □ W □ X*		
HOUSEHOLD INFORM	MATION I	Households are d	defined as s	pouses, pa	arent	s of m	inors, minors		-	arated, living apart living together	
Household Members PLEASE INCLUDE PATIENT INFORMATION		Date of Birth	Visa (Wo	gits of SS e of Valid rk, Visito nt, etc.)		US Citizen Legal Resident Y/N		Relationship to Patient		Tax Filing Status Choose Individual, Joint, Dependent, Not Filing	
								Self/Patient			
HOUSEHOLD INCOM	E List all inc	ome/no income f	or househol	ld member	rs list	ted abo	ove including	patient.			
Name of household member with or without income in the past 12 months, from date of application DO NOT WRITE NIA	Income Source- Do Not Write N/A Employer Name, Self-Employment, Odd Jobs, No Income, Workman's, Unemployment Compensation, pensions, rental income, trust			Number of months with income	Number Current Gross		Current Gross Monthly	Yearly Gross Income List total income for the past 12 months from date of application	Circl Med	Have you applied for any program listed below in the past 12 months: Circle all that apply Medicaid Social Security Disability	
Self/Patient										County Medical Coverage	
										Workers Compensation	
									Hea	Health Insurance Marketplace	
			Total:								
If you are claiming No Income	e, tell us wh	o is supporting	you								
Is there health/auto insurance to cover any cost of your medical care? Yes Insurance/Policy#											
ATTENTION MEDICARE RECIPIENTS: Federal regulations require Medicare recipients to provide proof of income and assets when											
applying for hospital assistar	ice.										
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		W	/itnes	ss Sigi	nature (No	tary not required)		Date	