Appendix B (Financial Assistance Application)

UF Health Jacksonville
Financial Assistance Program

Application for Financial Assistance

In order to be considered for Financial Assistance, please complete the attached Financial Statement in its entirety. The Financial Statement is not complete unless signed by the appropriate guarantor.

Applicants must provide verification of income and identification for all members of the Family Unit for the period of no less than 90 days or 12 months prior to the date services were rendered.

> **Family Unit:** An individual, his/her spouse, birth child(ren), adopted child(ren) to include the unborn child who reside together at the same place of residence. The child(ren) must be age 17 or under to be included in the Family Unit. However, an emancipated minor must provide some form of documented proof to be considered for Financial Assistance as a separate family unit.

Acceptable forms of income verification are limited to *(legible copies are acceptable):*

- Income from wages
- Income from self-employment
- Alimony
- Child Support
- Military family-allotments
- Public Assistance
- Pension/retirement
- Unemployment compensation
- Workers' compensation
- Grants and scholarships in excess of the cost of tuition and books
- W-2 withholding forms
- Pay Stubs (most recent 90 days or 12 months)
- Income Tax returns (most current)
- Written verification of wages from employer or third party payment source
- Written verification from public agencies which can attest to the applicant's income such as Social Security, Supplemental Security Income, Veteran's Administration, and Railroad Retirement.
- Previous 3 or 12 months of bank statements
- Survivor Benefits
- Disability Payments
- Interest or Dividends
- Rent
- Royalties
- Income from estates or trusts
- Notarized statement of support that verifies support received for the proceeding 90 days or 12 months
- Income from other miscellaneous sources

Upon determination of your eligibility, you will be notified in writing.

COMPLETED APPLICATIONS AND COPIES OF SUPPORTING DOCUMENTATION MAY BE RETURNED IN PERSON OR BY MAIL TO:

Attn: UF Health Jacksonville
Financial Evaluation Department
655 West 8th Street
Jacksonville, Florida 32209

If you have any questions, please contact (904) 244-4015

enroll@jax.ufl.edu

http://ufhealthjax.org/patient-care/financial-assistance.aspx

Appendix B (Financial Assistance Application)

UF Health Jacksonville FINANCIAL STATEMENT

PATIENT NAME | MEDICAL RECORD NO. | NO. DEPENDENTS (TOTAL IN HOUSEHOLD)

RESPONSIBLE PARTY

NAME OF RESPONSIBLE PARTY		SOCIAL SECURITY NUMBER	DATE OF BIRTH	REL TO PT	GUARANT OR I.D.
ADDRESS	CITY	STATE	ZIP	HOME PHONE	
EMPLOYER NAME	ADDRESS	CITY			
STATE	ZIP	WORK PHONE	HOW LONG	GROSS SALARY	
PREVIOUS EMPLOYER NAME	ADDRESS	CITY			
STATE	ZIP	WORK PHONE	HOW LONG	GROSS SALARY	

SPOUSE

SPOUSES NAME		SOCIAL SECURITY NUMBER	BIRTHDATE		
ADDRESS	CITY	STATE	ZIP	HOME PHONE	
EMPLOYER NAME	ADDRESS	CITY			
STATE	ZIP	HOME PHONE	HOW LONG	GROSS SALARY	

NCOME

Income

GROSS SALARY (AP)	CHILD SUPPORT/ALIMONY	RENTAL INCOME	SOCIAL SECURITY/SSI	RETIRED OR DISABILITY	
WORKERS" COMPENSATION	INTEREST/DIVIDENDS	PUBLIC ASSISTANCE	UNEMPLOYMENT	PENSIONS	ROYALTIES
INCOME FROM ESTATES	EDUCATIONAL ASSISTANCE	SELF EMPLOYMENT	DEPENDENT INCOME	OTHER	TOTAL INCOME

LIABILITIES

SHELTER

RENT (HOME)	RENT(LAND)	MORTGAGE PAYMENT	OTHER	TOTAL SHELTER

UTILITY

ELECTRIC	WATER	TELEPHONE	GAS		TOTAL UTILITIES

VEHICLE EXP

PRIMARY MAKE/YEAR	BALANCE OWED	MONTHLY PAYMENTS	GAS/MONTH (All vehicles)	
SECONARY MAKE/YEAR	BALANCE OWED	MONTHLY PAYMENTS	INSURANCE/MO (All vehicles)	TOTAL TRANSPORTATION

MISCELLANEOUS

INSURANCE (Specify per month per year)	HEALTH	LIFE	BALANCE OWED	MONTHLY PAYMENTS	CHILD CARE (PER MONTH)	FOOD
CREDITOR	BALANCE OWED	MONTHLY PAYMENS				
CREDITOR	BALANCE OWED	MONTHLY PAYMENTS				
CREDITOR	BALANCE OWED	MONTHLY PAYMENTS		TOTAL MISCELLANEOUS		

OTHER LOANS

NAME	BALANCE OWED	MONTHLY PAYMENTS		
NAME	BALANCE OWED	MONTHLY PAYMENTS	TOTAL OTHER EXPENSES	TOTAL LIABILITIES

I certify that the information contained herein is true and accurate to the best of my knowledge, and that I have no other income assets or liabilities except those listed. I understand that to intentionally give false or inaccurate information may constitute fraud in violation of 817.50 Florida statutes. I authorize the Hospital and Physicians to make any inquires or obtain any information deemed necessary to verify the accuracy of the information contained herein. I authorize any financial institutions, the Social Security Office, the Credit Bureau, my creditors, landlord, and past and present employers to release any information or documentation requested by the Hospital or Physicians to verify the information provided herein.

SIGNATURE	DATE	WITNESS	DATE