PATIENT / APPLICANT FINANCIAL STATEMENT

ACCOUNT #

AdventHealth
RETURN TO ADDRESS CHECKED

☐ **ORLANDO** 601 E. ROLLINS ST. ORLANDO, FL 32803-6800 **Telephone:** A-D . 407-303-1735 E-K . 407-303-2745 L-RI . 407-303-1895 RO-Z 407-303-2746 OB/Peds/Neonatal 407-303-7664	☐ **ALTAMONTE** 601 E. ALTAMONTE AVE. ALTAMONTE SPRINGS, FL 32701 **Telephone:** A-K .....407-303-2301 L-Z.....407-303-2383	☐ **EAST ORLANDO** 7727 LK. UNDERHILL DR. ORLANDO, FL 32822 **Telephone:** A-K 407-303-8625 L-Z 407-303-8655	
☐ **KISSIMMEE** 2450 N. ORANGE BLOSSOM TRAIL KISSIMMEE, FL 34772 **Telephone:** A-Z.. 407-933-6649	☐ **APOPKA** 201 N. PARK AVE. APOPKA, FL 32703 **Telephone:** A-Z . 407-889-1940	☐ **CELEBRATION** 400 CELEBRATION PL. CELEBRATION, FL 34747 **Telephone:** A-K ..... 407-303-4857 L-Z 407-303-4397	☐ **WINTER PARK** 200 N. LAKEMONT AVE. ORLANDO, FL 32792 **Telephone:** A-K ..... 407-599-6017 L-Z 407-599-6016

LIST ALL *HOUSEHOLD FAMILY MEMBERS* BY LEGAL NAME

PROOF OF ANY INCOME MAY BE REQUIRED AT THE FINANCE COMMITTEE'S DISCRETION

☐ I need financial assistance. ☐ I do not need financial assistance.

LAST NAME	FIRST	DATE OF BIRTH	AGE	RELATION TO PATIENT	OCCUPATION	SOCIAL SECURITY NUMBER	LAST YEAR'S ANNUAL GROSS INCOME
		/ /		PATIENT			
		/ /					
		/ /					
		/ /					
		/ /					
		/ /					

PATIENT INFORMATION

County of Residence:

Home Telephone Number:

Third party / COBRA assistance - If unemployed and you were previously covered by health insurance, do you need assistance for premium coverage? Yes ☐ or No ☐

Date of last worked day_____

Have you applied for Medicaid or county assistance? Yes ☐ or No ☐

If yes, when and where?

Have you applied for WIC/food stamps? Yes ☐ or No ☐

If yes, when and where?

Have you applied for social security disability (SSI/SSD)? Yes ☐ or No ☐

If yes, when and where?

Has the patient been hospitalized in the last 60 days? Yes ☐ or No ☐

If yes, when and where?

GUARANTOR / PATIENT COMMENTS

SOCIAL SECURITY INCOME	$
STATE AID - SSI, AFDC, MEDICAID	$
FOOD STAMPS	$
PENSION INCOME	$
SAVINGS INTEREST	$
WORKERS COMP. INCOME	$
UNEMPLOYMENT COMPENSATION	$
CHILD SUPPORT / ALIMONY RECD	$
RENTAL INCOME	$
MONEY FROM FAMILY / OTHER	$
LAST 30 DAYS INCOME	

LAST YEAR'S ANNUAL GROSS INCOME $
REQUIRED

ASSETS

HOME ADDRESS (NOT P.O. BOX)
HOMESTEAD ☐ YES MOBILE HOME ☐ YES RENT ☐ YES ( ) YRS. PAID ON HOME

BAL. OWED $ TAX ASSESSED VALUE $ MARKET VALUE $

1ST CAR ( ) YR. ( ) MODEL ( ) VALUE $

2ND CAR ( ) YR. ( ) MODEL ( ) VALUE $

BOAT ( ) YR. ( ) MODEL ( ) VALUE $

MOTOR HOME ( ) YR. ( ) MODEL ( ) VALUE $

OTHER PROPERTY
RENTAL ☐ VACANT LAND ☐ BAL. OWED $ VALUE $

BANK NAME / CREDIT UNION ACCT # REQUIRED AVERAGE CHECKING/SAVINGS BALANCE $

BANK NAME / CREDIT UNION ACCT # REQUIRED AVERAGE CHECKING/SAVINGS BALANCE $

C.D.'S - BANK NAME BALANCE $

STOCKS / BONDS - BROKER FIRM IRA / TRUSTS / 401k LIST OTHER ASSETS VALUE $

VALUE $

VALUE $

THE VALUE OF ALL ASSETS LISTED ABOVE ..... TOTAL $ _____

MONTHLY LIVING EXPENSES

PAYMENT TO	FOR	TOTAL AMT OWED	AMT DUE EACH MONTH	AMT PAST DUE
MEDICAL	FLORIDA HOSPITAL	$	$	$
"	OTHER HOSPITALS (ALL)	$	$	$
"	DOCTORS (ALL)	$	$	$
"	MEDICATION	$ N/A	$	$ N/A
HOUSING	HOME MORTGAGE	$	$	$
"	2ND MORTGAGE	$	$	$
"	PROPERTY TAX	$	$	$
"	RENT	$ N/A	$	$
"	MOBILE HOME LOT	$ N/A	$	$
FOOD	GROCERIES / SCHOOL / WORK / LUNCHES	$ N/A	$	$ N/A
UTILITIES	ELECTRIC / GARBAGE / GAS / WATER	$ N/A	$	$
"	PHONE / CELLULAR / BEEPER	$ N/A	$	$
TRANSPORTATION	1ST CAR	$	$	$
"	2ND CAR	$	$	$
"	GASOLINE	$ N/A	$	$
LOANS	BOAT / MOTOR HOME	$	$	$
"	BANK / CREDIT UNION / FINANCE CO / LOANS	$	$	$
CHARGE CARDS	SUM OF ***ALL*** CREDIT CARDS	$	$	$
FAMILY	DAY CARE / BABY-SITTERS	$ N/A	$	$
"	CHILD SUPPORT / ALIMONY EXPENSE	$	$	$
"	SCHOOL TUITION	$	$	$
INSURANCE	AUTO INSURANCE	$	$	$
"	MEDICAL INSURANCE	$	$	$
"	LIFE INSURANCE	$	$	$
"	RENTERS INSURANCE	$	$	$
ENTERTAINMENT	ALCOHOL / TOBACCO	$ N/A	$	$ N/A
RECREATION	CABLE TV / SATELLITE SERV / DSS / VIDEOS	$ N/A	$	$
	IRS / JUDGMENTS / LIENS / OTHER	$	$	$
DONATIONS	CHURCH / SYNAGOGUE / OTHER	$ N/A	$	$ N/A
	TOTALS	$	$	$
		(ANNUALIZED) X12 =		

AGREEMENT

Please read before signing. I CERTIFY the information I have provided is true and accurate to the best of my knowledge. I will make application for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay this hospital bill and will take all action necessary to obtain assistance from the above sources. I further understand that if Florida Hospital determines that I am eligible for a charity reduction on my balance, I will be responsible for a non-refundable fee of $100.00. I understand that if I do not cooperate with FLORIDA HOSPITAL within 45 days from the date of service in requesting ANYadditional information, my application may be denied for possible financial assistance. I hereby grant permission and authorize any accredited agent of the Department of Children and Families to disclose to Florida Hospital ALLinformation regarding the status of my Medicaid application and if the application is not approved, the reason for disapproval. I will ASSIGN to FLORIDA HOSPITAL ALL FUNDS received from the above sources, which are provided to help with this HOSPITALBILL. I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain in strictest confidence any written communications and/or oral discussions between me and Florida Hospital regarding matters relating to services provided to me by Florida Hospital. I understand that the information which I submit is subject to verification by FLORIDAHOSPITAL, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I AUTHORIZE my employer to release to FLORIDAHOSPITALproof of my income. I UNDERSTAND that if any information I have given proves to be untrue, FLORIDA HOSPITAL will re-evaluate my financial status and take whatever action becomes appropriate. Should additional information become available, Florida Hospital reserves the right to reconsider this decision not limited to first or third party recovery settlement or inheritance. Florida Statute s.817.50 (1) Whoever shall, willfully and with intent to defraud, obtain or attempt to obtain goods, products, merchandise or services from any hospital in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in s.775.082 or s.775-083.

SIGNATURE OF APPLICANT	*AND/OR CO-APPLICANT/SPOUSE*	*DATE*	*WITNESS*
SIGNATURE REQUIRED	SIGNATURE REQUIRED		SIGNATURE REQUIRED

FOR OFFICE USE ONLY

FAMILY SIZE	GAI	RICS	CHECK:	☐ 1.0X (CW) $	☐ 1.5X (CX) $	☐ 2.0X (CY) $	☐ 25% RULE (C25) $	☐ Expired (CE) ☐ Homeless (CZ)

REASON FOR SERVICE:

FINC RECOMM

ACCOUNT #	DOS	BALANCE DUE	IP	OP	BD	COMMITTEE DISPOSITION
TOTAL DUE	$					