LEE HEALTH

Financial Assistance Application

Admit Date: _____ HAR #: _____ Telephone#: _____ Date of Birth: _____

Patient Name: _____ Social Security #: _____ Marital Status: S M D X W

Physical Address: _____ Mailing Address: _____

HOUSEHOLD COMPOSITION (PERSON/PERSONS LIVING AT HOME)

NAME (Last, First, Middle)	SEX	AGE	DOB	RELATIONSHIP	ANNUAL INCOME

ANNUAL INCOME INFORMATION (PREVIOUS 12 MONTHS FROM DATE OF ADMISSION)

#1 PATIENT/GUAR EMPLOYER (current): _____ **LENGTH OF EMPLOYMENT:** _____ **Phone#:** _____

If employed < 12 months, must complete section #2

Gross wages: _____ ❑ Hourly ❑ Weekly ❑ Monthly ❑ Yearly Number of hours per week: _____

Do you own the business?: ❑ Yes ❑ No If Yes, please provide personal & business Tax Returns.

#2 EMPLOYER (previous/past): _____ **LENGTH OF EMPLOYMENT:** _____ **Phone#:** _____

Gross wages: _____ ❑ Hourly ❑ Weekly ❑ Monthly ❑ Yearly Number of hours per week: _____

#3 SPOUSE/SIG. OTHER EMPLOYER (current): _____ **LENGTH OF EMPLOYMENT:** _____ **Phone#:** _____

If < 12 months, must complete section #4

Gross wages: _____ ❑ Hourly ❑ Weekly ❑ Monthly ❑ Yearly Number of hours per week: _____

Do you own the business?: ❑ Yes ❑ No If Yes, please provide personal & business Tax Returns.

#4 EMPLOYER (previous/past): _____ **LENGTH OF EMPLOYMENT:** _____ **Phone#:** _____

Gross wages: _____ ❑ Hourly ❑ Weekly ❑ Monthly ❑ Yearly Number of hours per week: _____

Retirement benefits:	❑ Yes ❑ No	Amount $: _____		Unemployment:	❑ Yes ❑ No	Amount $: _____	
Disability benefits:	❑ Yes ❑ No	Amount $: _____		Rental Income:	❑ Yes ❑ No	Amount $: _____	
Other Household Income	❑ Yes ❑ No	Amount $: _____		SS benefits:	❑ Yes ❑ No	Amount $: _____	
VA?	❑ Yes ❑ No	Amount $: _____		IRA's?	❑ Yes ❑ No	Amount $: _____	

ASSET INFORMATION

Name of Bank: _____ Checking: $ _____ Savings: $_____ Money Mkt: $ _____

Stocks? ❑ Yes ❑ No $ _____ Bonds? ❑ Yes ❑ No $ _____ CD's ❑ Yes ❑ No $ _____

Home: Own? ❑ Yes ❑ No Rent: ❑ Yes ❑ No Buying ❑ Yes ❑ No What is monthly payment? $ _____

Do you own other property: ❑ Yes ❑ No If Yes, what is the location? _____

Vehicle 1 Year: _____ Make: _____ Balance owed or monthly payment: $ _____

Vehicle 2 Year: _____ Make: _____ Balance owed or monthly payment: $ _____

Vehicle 3 Year: _____ Make: _____ Balance owed or monthly payment: $ _____

MEDICAID/AFFORDABLE CARE ACT (ACA) QUESTIONNAIRE

Have you ever applied for Medicaid/ACA? ❑ Yes ❑ No When: _____ Where: _____

Comments: _____

COMBINED GROSS INCOME FOR THE PAST 12 (TWELVE) MONTHS HAS BEEN $ _____ AND THERE ARE _____ (# OF) PEOPLE IN MY FAMILY. THE INCOME INFORMATION CAN BE VERIFIED BY CALLING THE ABOVE EMPLOYERS. ADDITIONALLY, I UNDERSTAND THAT IN ACCORDANCE WITH FLORIDA STATUTES 817.50, PROVIDING FALSE INFORMATION TO DEFRAUD A HOSPITAL FOR THE PURPOSES OF OBTAINING GOODS OR SERVICES IS A MISDEMEANOR IN THE SECOND DEGREE. FURTHER, THE UNDERSIGNED HEREBY CONSENTS TO THE HOSPITAL'S INQUIRIES INTO HIS/HER CREDIT HISTORY IN CONFORMITY WITH THE LEGITIMATE BUSINESS NEEDS AND APPLICABLE LAWS, RULES, AND REGULATIONS.

IN THE EVENT THAT ASSETS OR A PAYMENT BECOME AVAILABLE, LEE HEALTH RESERVES THE RIGHT TO REVERSE THE ORIGINAL ADJUSTMENT.

LEE HEALTH MAY REQUEST ADDITIONAL DOCUMENTS IN SUPPORT OF THIS APPLICATION, AS DESCRIBED IN THE FINANCIAL ASSISTANCE POLICY.

I HEREBY CERTIFY THE ABOVE INFORMATION TO BE TRUE AND CORRECT.

Copies of the Lee Health Financial Assistance Policy and additional information are available at www.LeeHealth.org.

If you have any questions or need help, Financial Counselors are available at 800-809-9906

_____ _____ _____

Patient/Guarantors Signature Date Witness Signature

_____ _____

Spouse Signature Date