BAPTIST HEALTH

Baptist Jacksonville
Baptist South
Baptist Beaches
Baptist Nassau
Baptist Clay
Baptist Town Center
Baptist North
Baptist Oakleaf
Wolfson Children's Hospital
Baptist Behavioral Health

Financial Assistance Application for Hospital Services

Date:	Account:

Patient Information		Guarantor Information (if different than patient)	
Name:		Name:	
Street:		Street:	
City:		City:	
State:	Zip Code:	State:	Zip Code:
Home Phone:		Home Phone:	
Work Phone:		Work Phone:	
Date of Birth:		Date of Birth:	
Social Security #:		Social Security #:	
Marital Status:		Marital Status:	

Include information for self, spouse, dependent children under age 18 living in household and dependent full-time students under age 25

Name	Relationship	Date of Birth	Social Security #

Employment /Income History

List employment and other sources/amounts of weekly income for the past twelve (12) months for all family members

Family Member	Employer	Employer Telephone #	Monthly Wages	Date of Employment MM/YR – MM/YR

Other Income History

List all other sources of monthly income for the past twelve (12) months for all family members

Other Monthly Income	Family Member Name	From	To	Amount
Social Security				
Investment Income				
Pension				
SSI				
Unemployment				
Worker's Comp				
Alimony				
TANF				
VA Benefits				
Rental Property				
Insurance Annuity				
Child Support				
Interest Income				
Other				
Total Other Income				
Grand Total Wages and Other Income				

Assets

Cash, Savings, Checking Accounts	$
Certificate of Deposits	$
U.S. Savings Bond, U.S. Treasury Bonds/Bills	$
Stocks, Mutual Funds, Trust Funds	$
Retirement Income (401K, 403K, IRA's)	$
Do you own secondary homes/property other than your primary residence: Yes No	$ (Fair Market Value)
Secondary home/property address	
Total Assets	$

I hereby authorize my and/or my spouse current and past employers to release employment and salary information to Baptist Health System. I hereby certify that the information on this application for Financial Assistance is true and correct to the best of my knowledge. Baptist Health System, at its sole discretion, may require proof of income to validate charity care eligibility.

I hereby authorize Baptist Health to obtain a credit report to assist in the evaluation of my financial assistance application.

In accordance with Section 817.50 of the Florida Statues, providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree.

Applicant/Guarantor: _____ Date: _____

Witness: _____ Date: _____

Hospital Representative: _____ Date: _____

For Hospital Verification of Wages

Employer:	Verified Wages:
Company Representative:	Employee Signature: