Baptist Health Financial Assistance Program

If you need help paying for health care services received at a Baptist Health Hospital location, our Financial Assistance Program (FAP), may be able to help you. Please complete this application in its entirety so that our Patient Financial Advocates can review and process your application timely. Any missing or unclear information may delay the application process or result in a denial.

In addition to your application, you may be asked to provide the following support below:

Household Income Type	Documentation Needed
Employment income wages	• Most recent paystub with year-to-date gross wages; OR • At least most recent full month's paystubs
Self-employed business income or Rental Property income	• Most recent tax return with all schedules; OR • Profit and Loss Statement; OR • Rental Agreement(s)
Investment Income (Interest, Dividends, etc.)	• Most recent tax return with all schedules; OR • Investment Statements
Unemployment benefits or Workman's Compensation income	• Payment Summary showing your gross weekly benefits
Alimony or child support	• Most recent tax return with all schedules; OR • Court Divorce Decree / amount awarded
Pension or retirement/annuity income	• Most recent tax return with all schedules; OR • Monthly gross benefit letter
Social Security/Supplemental Security Income or Veterans Benefits	• Most recent tax return with all schedules; OR • Monthly gross benefit letter

Household Asset Type	Documentation Needed
Cash	• Current Bank Statement for all Checking and Savings accounts
Investments (CDs, US Savings Bonds, US Treasury Bills, Stocks, Money Market Funds, Mutual Funds, Trust Funds, etc.)	• Investment Statements showing balances
Secondary Home	• Mortgage Statement (other than primary residence); OR • Property Tax Bill / Statement

Household members	Documentation Needed
Dependent Children under age 18 living with you	• Most recent tax return with all schedules; OR • Guardianship papers; OR • Court Divorce Decree
Dependent Children under age 25 who are full-time students	• Most recent tax return with all schedules; OR • Proof of school enrollment
Qualifying Relative living with you (Parent, In-Law, Sibling, Niece, Nephew)	• Most recent tax return with all schedules showing proof you claim them on your tax return

How to submit your application:

Apply online at: www.My.BaptistChart.com

Email us at: PFSFAAPPT@bmcjax.com

In Person at: **Any of our Baptist Hospital Locations**
Or our **San Marco East Location** at:
3563 Philips Highway,
BLDG B, STE 201
Jacksonville, FL 32207

Send Mail to:
Baptist Health Jacksonville
P.O. Box 736048
Dallas, TX 75373-6048
Attn: Patient Financial Advocate

Questions? Call 904.202.2092

Financial Assistance Application for Hospital Services

Patient Name:_____ **Phone Number :**(_____) _____-_____
Date of Birth:_____/_____/_____ **SSN:**_____-_____-_____ **Email Address:**_____
Address:_____
City:_____ **State:**_____ **ZIP Code:**_____

Pregnant: ☐ **Yes** ☐ **No** **Disabled:** ☐ **Yes** ☐ **No** **Homeless:** ☐ **Yes** ☐ **No** **Marital Status:**

Is there health/auto insurance to cover any cost of your medical care? ☐ **Yes** _____ ☐ **No**
Insurance/Policy#

Household Members: List self, spouse, and all dependents living with you whom you support including, children under 18 or who are full-time college students under 25 (biological, adopted, step, other legally dependent child), parent, in-law, sibling, niece, or nephew.

Household Member Name(s)	Date of Birth	Last 4 digits of SS#	Relationship to Patient	Tax Filing Status
Self / Patient			Self / Patient	

Household Income: List all income or "no income" for all household family members listed above - including yourself.

Household Member Name(s) with or without income (including yourself)	Income Source Employer Name, Self-Employed, Rental Income, Investment Income, Workman's Comp, Unemployment, Alimony/Child Support, Pension/Retirement/Annuities, Social Security, VA Benefits, **or "No Income"**. If you do not know, write "Unknown".	Number of Months with Income or Without Income	Current Gross Monthly Income	Yearly Gross Income List total Income
Self / Patient*				

***If you are claiming "No Income", tell us who is supporting you: Name:** _____ **Relationship:**

Household Assets: List all assets or "no assets" for all household family members listed above - including yourself. *

Household Member Name(s)	Asset Type	Total Current Dollar Amount of Asset
Self / Patient		

*If the total of all assets exceeds $75k, any amount over $75k will be considered income for purposes of this calculation.

Attention Medicare Recipients: Federal regulations require Medicare recipients to provide proof of income and assets when applying for hospital financial assistance.

Baptist Health 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 Baptist Health authorization to verify information given through a consumer credit report, if needed.

_____ _____
Patient / Guarantor Signature **Date**

IF MORE LINES ARE NEEDED, PLEASE REQUEST PAGE 2.

Questions? Contact Us.
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