HALIFAX HEALTH – PATIENT ASSISTANCE
303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
(386) 425–4019

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

FINANCIAL ASSISTANCE ASSESSMENT

General Assessment

Date:____

1. Do you have any dependent children living in the household? ❑ No ❑ Yes – ________________________________
2. Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Single
3. Do you have insurance? ❑ No ❑ Yes – ____
4. Were you ever a member of the US Military? ❑ No ❑ Yes – Did you apply for VA benefits? ____________________
5. Do you have any pending lawsuits? ❑ No ❑ Yes – ______________________________________

   Have you received any settlements? ❑ No ❑ Yes – ______________________________________
6. Do you have any stocks, bonds, pensions (401K or 403B), IRAs, CDs, inheritance or trust funds?

   ❑ No ❑ Yes – ____
7. Do you have a checking/savings account? ❑ No ❑ Yes – ________________________________
8. Do you own any property? ❑ No ❑ Yes – ____
9. Are you self–employed? ❑ No ❑ Yes – ____
10. Is your injury due to being a victim of a crime or auto accident? ❑ No ❑ Yes – ________________________
11. Have you applied for Medicaid? ❑ No ❑ Yes – ____
12. Have you applied for Social Security Disability? ❑ No ❑ Yes –________________________________
13. Are you eligible for Cobra or insurance benefits from a current employer? ❑ No ❑ Yes –__________________
14. Are you a natural born citizen? ❑ No ❑ Yes – Where were you born? ____________________________
15. Have you sold or given away property or assets within the last 5 years? ❑ No ❑ Yes – __________________
16. Current Medications –____

    ____
17. Last Physician seen and when –____
18. Are you fleeing the law due to a felony/probation/parole violation? ❑ No ❑ Yes – ______________________

Other Comments: ____

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Patient Signature:____ Date:__________________

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FINANCIAL ASSISTANCE ASSESSMENT
Financial Assessment

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

Address:_______________________________________ Phone: (______)_______________
Employer:_______________________________________ Phone: (______)_______________
Self Employed (Check one): ❑ No ❑ Yes –_______________________________________
Nearest Relative:_______________________________________ Phone: (______)_______________
Total in Household:____________________ Total Dependents:____________________
Gross Annual Income: $____________________ Social Security #:____________________
Bank Name:____________________ Checking Acct. Balance: $__________ Savings Acct. Balance: $__________
Bank Name:____________________ Checking Acct. Balance: $__________ Savings Acct. Balance: $__________
Family Automobile(s):
Make:_______________ Model:______________________________ Year:__________
Make:_______________ Model:______________________________ Year:__________

Monthly Expenses:

Rent / Mortgage: (specify which)	$__________	Amount of Mortgage:	$__________
Automobile: (if leased or financed)	$__________	Amount Financed:	$__________
Utilities:	$__________		
Loans:	$__________	Amount of Loan:	$__________
Credit Cards:	$__________		
Insurance: (car / home)	$__________		
Child Support / Alimony:	$__________		
Child Care:	$__________		
Food:	$__________		
Clothing:	$__________		
Transportation:	$__________		
Other:	$__________		
Total Monthly Expenses:	**$**__________		

THE INFORMATION CONTAINED IN THIS FINANCIAL ASSESSMENT IS SUBJECT TO VERIFICATION

I, the undersigned, do hereby swear and certify that the information contained herein is true and correct. Halifax Health may use my personal information, including my Social Security Number, to verify the accuracy of the information you provide, insurance and payment purposes, to help identify and prevent fraud or other criminal activity, to match, verify, or retrieve existing information, to help prevent medical errors, or for research activities. I hereby grant permission and authorize any bank, building association, insurance company, real estate company, financial institution, or credit grantor of any kind to disclose to any authorized agent of Halifax Health, information of my past and present accounts and policies. I understand that providing false information to defraud Halifax Health for the purpose of obtaining goods or services is a misdemeanor in the second degree in accordance with s.817.50, Florida Statutes. I authorize this information be made available to all providers who participate in the Halifax Assistance program, should I be accepted. I agree to reimburse Halifax Health for the care and treatment in the event I recover any money for the injuries giving rise to the treatment. Any reimbursement shall be made at the rate found on the Halifax Health Charge Master at the time of service.

Patient Signature:_______________________________________ Date:____________________

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FINANCIAL ASSISTANCE ASSESSMENT

Verification Assessment *(if applicable)*

SELF–DECLARATION OF INCOME:

This is to certify that I, ______________________________ (print Patient's name) at current address ______________________________ declare the following statements.

I made $______________ from the period of ______________ to ______________ as a

❑ Self–employed person, ❑ Doing odd jobs, or ❑ Jobs paid in cash/no paystubs given.

VERIFICATION OF SUPPORT:

______________________________ (print Patient's name), is presently residing at ______________________________ (print Address). I,______________________________

(print Party providing support name), am providing food and living expenses to Patient with an estimated monthly cost totaling

$______________,

Social Security Number of Party Providing Support: ______________________________

I ❑ did ❑ did not declare ______________________________ as a dependent on my last tax return.

Failure to provide complete and accurate information may result in the denial of benefits for the Patient.

Other Comments: ______________________________

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Signature of Party Providing Support:______________________________ Date:______________

Patient Signature:______________________________ Date:______________