

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: _____

Patient Signature: _____ **Date:** _____



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Financial Assessment

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: _____

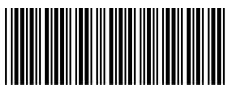
Monthly Expenses:

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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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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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.

Signature of Party Providing Support: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

