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
MR # Visit #

VOLUSIA/FLAGLER HOMELESS COALITION APPLICATION

Name:_____ Date of Birth:_____

Social Security #:_____ Sex: ❑ Male ❑ Female

Current Monthly Income: $_____ Employer:_____

Please list any medications you currently take or require: _____

_____

Please list any known health condition(s) you have (high blood pressure, diabetes, etc.): _____

_____

_____

STATEMENT OF FINAL CLEARANCE

I, the undersigned, do hereby swear the information contained herein is true and correct. 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 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.

I understand that Halifax Health reserves the right to deny or suspend my eligibility under this program in the event that I am non−compliant, engage in any illegal activity pertinent to my care and/or act inappropriately to any agent of Halifax Health.

My care is related to an accident case which is pending litigation/settlement: ❑ Yes ❑ No

Attorney Name & Phone Number:_____

Signed:_____ Date:_____

Witness:_____ Date:_____

HMC 95

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HEALTH SURVEY

Name:_____ Date:_____

This Health Survey is to be completed on all new and renewal applications. The answers on this survey do NOT affect acceptance to the Halifax Health − Patient Assistance program.

Please list all physicians you have seen in the last 12 months and list the month and year of your last visit:

_____

_____

Do you smoke? ❑ No ❑ Yes − How many packs per day? _____ How long have you smoked? _____ years

Do you drink alcohol? ❑ No ❑ Yes − How many drinks per day? _____
What do you drink? ❑ Beer ❑ Liquor ❑ Wine

Please list all hospitalizations or surgeries you have had (include month and year):

_____

_____

_____

Where were you born?_____

Are you a veteran of any U.S. Military Service? ❑ No ❑ Yes − Which branch?_____

Are you currently receiving any Social Security Benefits? ❑ No ❑ Yes − What is your monthly benefit amount?_____

Please list all medicines you take on a daily basis (include all herbs and over the counter medicine):

Name of Medicine:	How Often:	What for:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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HEALTH SURVEY (continued)

Name:_____ Date:_____

Have you ever been diagnosed with any of the following conditions?

Medical Condition	Y / N	Date	What medicine do you take for this?	Comments
Degenerative Joint Disease − what joint(s)?				
Arthritis − where?				
Cellulitis (infection of the skin) − where?				
Hernia				
Thyroid Disease				
Stroke				
Osteomylitis (infection in the bone)				
Hepatitis − Type and when diagnosed?				
Kidney disease − when diagnosed?				
High Blood Pressure				
Diabetes − what type?				
History of heart attack				
Emphysema or COPD				
Congestive Heart Failure				
Cancer − any type − please specify				

Your signature below means that the information provided is true and correct. False information can result in termination or limitation of Halifax Health − Patient Assistance (HHPA) benefits. Signing this form also indicates that you have received the sheet titled *Fast Facts* which outlines your responsibilities as an HHPA recipient and you agree to participate with the services offered.

Patient Signature:_____ Date:_____