Dear @GREALNAME@:

We are providing an application because you may qualify for our Financial Assistance Program. **In order to be considered for full assistance, you must complete, sign and provide all supporting documentation required from the attached Financial Assistance Application.**

**If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.** If you fail to provide all the necessary information, your application for Financial Assistance may be denied.

Please read the form carefully as it provides critical information for your approval in our Financial Assistance Program. Any missing or incomplete information will cause your application to be denied, or your approval to be delayed! Please be advised that both signatures, patient/guarantor and witness, are required for your application to be considered for approval.

As you may be aware, the Affordable Care Act went into effect on October 1, 2013. The Act provides all Americans the opportunity to have access to quality, affordable coverage. The Affordable Care Act intends to provide Americans with options and alternatives for health care coverage. Health Insurance Exchanges will provide a marketplace to assist people in choosing options for coverage that may be subsidized through tax credits for many Americans.

If you are interested in what is available, go to Healthcare.gov website that will allow you to enroll as well as provide some helpful FAQ's on the Affordable Healthcare Act.

**This program applies to services rendered by the UF Health Gainesville.**

Please allow 7 business days for our review process. We will notify you of our determination of qualification by letter. If you have any questions pertaining to this application, please contact one of our representatives at the numbers listed below.

Sincerely,

UF Health - Customer Service Department
**Financial Assistance Application**

**UF Health**
**Customer Service**
**P O Box 100334**
**Gainesville, Fl 32610-0334**

**Patient Name:** @PATREALNAME@
**Customer Service**
**MRN:** @MRN@
**Patient DOB:** @PATDOB@
**Guarantor:** @GREALNAME@
**Address:** @GADDR@
**Account Number:** @GID@
**GCSZ:**

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**DEPENDENTS IN FAMILY**

(This includes spouse, children under 18 and all others claimed on your and/or your spouse's tax return)

1. Name: (first, middle, last) ___________ DOB: ___________

2. ___________ DOB: ___________

3. ___________ DOB: ___________

4. ___________ DOB: ___________

5. ___________ DOB: ___________

6. ___________ DOB: ___________

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**PATIENT/GUARANTOR INFORMATION**

Social Security#: __________________________ Employer Name: ___________________________
Hourly Pay Rate: $ ___________ Average Hours Work Per Week: ___________
Current Gross Weekly, Monthly or Yearly Income: $ ___________
If Unemployed, last date worked: __/__/___

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**SPOUSE INFORMATION**

Social Security#: __________________________ Employer Name: ___________________________
Hourly Pay Rate: $ ___________ Average Hours Work Per Week: ___________
Current Gross Weekly, Monthly or Yearly Income: $ ___________
If Unemployed, last date worked: __/__/___

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**OTHER INCOME**

<table>
<thead>
<tr>
<th>Item</th>
<th>Patient/Guarantor</th>
<th>Spouse</th>
<th>Dependent(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td>$ ___________</td>
</tr>
<tr>
<td>Pension</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td>$ ___________</td>
</tr>
<tr>
<td>Unemployment</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td>$ ___________</td>
</tr>
<tr>
<td>Workers Compensation</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td>$ ___________</td>
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<tr>
<td>VA Benefits</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td>$ ___________</td>
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<tr>
<td>Child Support</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td>$ ___________</td>
</tr>
<tr>
<td>Alimony</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td>$ ___________</td>
</tr>
<tr>
<td>Rental Income</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td>$ ___________</td>
</tr>
</tbody>
</table>

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**ASSET INFORMATION**

<table>
<thead>
<tr>
<th>Item</th>
<th>Patient/Guarantor</th>
<th>Spouse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Value</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td></td>
</tr>
<tr>
<td>Balanced Owed</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td></td>
</tr>
<tr>
<td>Other Real Property Value/Assets</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td></td>
</tr>
<tr>
<td>Stocks/Bonds/CDs/IRAs</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td></td>
</tr>
<tr>
<td>Bank Account: Checking</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td></td>
</tr>
<tr>
<td>Bank Account: Saving</td>
<td>$ ___________</td>
<td>$ ___________</td>
<td></td>
</tr>
</tbody>
</table>

Have you applied for Medicaid or other assistance? Yes/No
If yes and approved please provide your Medicaid number ____________.
If yes and you have been denied please provide a copy of the denial letter.
If yes and pending application process please provide application# ____________.
If no, please contact your local Medicaid office to determine eligibility.

I certify that the above information is true and accurate. Furthermore, I authorize UF Health to make any inquiries or obtain any necessary information to verify the accuracy of the information contained herein including my employer, the Credit Bureau, my creditors or other financial institution if deemed necessary. In accordance with public law s.817.50 F.S., providing false information to defraud a hospital for the purpose of obtaining goods or service is a misdemeanor in the second (2nd) degree.

Signature: __________________ Date: __________________
Witness: __________________

Both signatures are required or your application will be denied.