RE: Account Number: MRN:

Dear:

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:
MRN:
Patient DOB:
Guarantor: Address:
Account Number:

**********DEPENDENTS IN FAMILY**********

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

Name:(first,middle,last)	DOB:	Name:(first,middle,last)	DOB:
1.		4.	
_____	_____	_____	_____
2.		5.	
_____	_____	_____	_____
3.		6.	
_____	_____	_____	_____

**********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: ____/___/___

**********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: ____/___/___

**********OTHER INCOME**********

Please provide supporting documentation for any of the below mentioned items if applicable.

	Patient/Guarantor	Spouse	Dependent(s)
Social Security	$_____	$_____	$_____
Pension	$_____	$_____	$_____
Unemployment	$_____	$_____	$_____
Worker's Compensation	$_____	$_____	$_____
VA Benefits	$_____	$_____	$_____
Child Support	$_____	$_____	$_____
Alimony	$_____	$_____	$_____
Rental Income	$_____	$_____	$_____

**********ASSET INFORMATION**********

Please provide supporting documentation for any of the below mentioned items if applicable.

	Patient/Guarantor	Spouse
Home Value	$_____	$_____
Balanced Owed	$_____	$_____
Other Real Property Value/Assets	$_____	$_____
Stocks/Bonds/CDs/IRAs	$_____	$_____
Bank Account: Checking	$_____	$_____
Bank Account: Saving	$_____	$_____

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. Futhermore, I authorize UF Health to make any inquiries or obtain any information necessary 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.