JUPITER MEDICAL CENTER

Financial Assistance Application Form

To be considered for financial assistance you **must provide** the following*:

☐ **A completed and signed Financial Assistance Application.**

☐ **Proof of Income:** (Please provide each of the following or an explanation of why not provided)

☐ Federal Income Tax return(s) for your household for the most recent calendar year.

☐ Bank Statements for all bank accounts for the last 2 months

☐ Two (2) most recent pay stubs or a statement from your employer regarding your income.

☐ ***If self-employed***, please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return.

☐ Unemployment statement showing denial or eligibility and amount receiving.

☐ Written documentation of **all** forms of income. *(i.e. trust funds, stock dividends, child support, alimony, social security, public assistance, food stamps, etc.)*

☐ If you have not had any income for the past three (3) months or there has been a recent change in your financial situation you **must** include a statement or letter explaining your situation. If someone else is supporting you, they must sign the support statement on page 4 of the application.

☐ **Identification**:
Two forms of identification. (i.e. *driver's license, government issued photo ID, social security card, birth certificate or pass-port)*

☐ **Any other information that demonstrates financial hardship or need for financial assistance.**
(i.e. public assistance award or denial letter, letter(s) of support, bank statements, etc.)

If for any reason, you cannot provide us the information requested, please attach a written statement explaining why you cannot provide this information.

Send completed application and documentations to:

Jupiter Medical Center
Attn: Patient Financial Counselor OR FAX: 561-263-4124
1210 S. Old Dixie Hwy.
Jupiter, FL 33458

Failure to submit all requested information may result in denial of your application. Applications should be returned within **14** days or request may be denied.

Please note that if financial assistance is granted it will only cover your medical bills from our facility. It will not apply to the bills for other medical providers, hospitals or physicians unless they specifically agree to accept it. **PLEASE CONTACT THE OTHER MEDICAL PROVIDERS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.**
When applying for financial assistance you are giving consent for us to make necessary inquiries to confirm financial obligations or references. If you have any questions, **please contact our financial counselor at 561 263-3820**.

JUPITER MEDICAL CENTER

Financial Assistance Application

Patient Information **Date:** _____

Acct Number(s):_____ **Total Amount Due:** _____

Patient Name: _____ Date of Birth: _____ SS#: _____

Spouse or Guarantor Name: _____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____ Years/months at residence: _____

Home Phone:_____ Cell Phone:_____ Other Phone:_____

Household Information:

Member Name	Age	Relationship	Employer	Annual Gross Income
		Self		

Total Family Size: _____ **Total Dependents:** _____ **Total Household Income: $**_____

Screening Information:

- Do you currently have health insurance? (Y/N)____ If yes, please provide insurance info below:
  - Insurance Name: _____ Policy # _____
  - Group Name/Number: _____
- Have you had health insurance that has been terminated in the past 3 months? (Y/N)____ If yes, complete the following:
  - What type of insurance? (i.e. Medicaid, BCBS, Tricare, etc.,) _____
  - Reason for insurance termination? _____
  - Did you apply for cobra insurance coverage? (Y/N) ____ If so, when? _____
  - Former Employer Name: _____
- Are you active duty or retired military? (Y/N)____ If so, are you eligible for VA Benefits? (Y/N)____
- Have you applied for Medicaid or Disability? (Y/N)____ If yes, complete the following:
  - When? _____ Where? _____
  - Caseworker? _____
  - Has your household or income status changed since you last applied? (Y/N)____
- Were you a victim of a crime? (Y/N)____ If yes, complete the following.
  - Have you filed a Police Report? (Y/N)____ (Must be filed within 72 hrs. of incident)
  - Completed Victim of Crime application? (Y/N)____
- If you have any other special circumstances which you would like us to consider when reviewing your application, please explain below:

_____
_____
_____
_____
_____

JUPITER MEDICAL CENTER

Financial Assessment

Account Number(s)_____

Patients Name_____ Date:_____

Monthly Expenses

Rent/Mortgage $_____
Utilities $_____
Food $_____
Cell Phone/Pager $_____
Cable $_____
Auto Loan $_____
Auto Insurance $_____
Loans $_____
Child Support $_____
Credit Card(Min Payment) $_____
Other $_____
$_____
$_____

Assets

Checking Account(s) $_____
Savings Account(s) $_____
Other Cash Assets $_____
Credit Cards (Available Credit) $_____

Monthly Gross Income

Employment Income $_____
Spouse Income $_____
Retirement Income $_____
Food Stamps $_____
Government Benefits $_____
Child Support $_____
Other $_____

Total Expenses $_____ Total Income $_____

TOTAL MONTHLY INCOME **$**_____

TOTAL MONTHLY EXPENSES **$**_____

AMOUNT AVAILABLE **$**_____

Patient/Guarantor Certification

I, _____, CERTIFY the information I have provided is true and accurate to the best of knowledge. I understand that if I do not cooperate with the hospital in supplying ANY additional requested information; my application may be denied for possible financial assistance. I understand that the information which I submit is subject to verification by the HOSPITAL, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I understand that this application pertains to hospital charges and not physician's charges. I understand that if any information I have given proves to be untrue, the HOSPITAL will re-evaluate my financial status and take whatever action becomes appropriate. I am also aware that I am only applying for the accounts specified above, and that my financial status will have to be reevaluated and may require a new application for any/all future treatment I receive at Jupiter Medical Center.

_____ _____
Patient/Guarantor Signature Date

For Office Use Only

Reviewed by:_____ Date: _____ Recommendation: ○ Charity _____% ○ Indigent ○ Denied: Reason _____	Approved by: _____ Date _____ _____ Date _____ _____ Date _____

JUPITER MEDICAL CENTER

Additional Financial Documentation
(Only completed when applicable)

Account Number(s)_____

Patients Name_____ Date:_____

_____ **Support Statement:**

My signature will certify that I, _____, do provide all necessary essentials for living for the patient's behalf, and have done so for a period of _____ years / months.

_____ _____ _____
Signature of Patient's Supporter Relation to Patient Date

_____ **Homeless Affidavit**

I, (PRINT NAME) _____ hereby certify that I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

_____ _____
Signature Date

_____ **No Changes to Financial Status since Previous Application for Assistance**

I, (PRINT NAME) _____ hereby certify there have been no changes to my (nor my spouse's) financial status since my previous application for financial assistance from Jupiter Medical Center which was completed on _____. Please select of the following options:

☐ I am still being supported by another. They do provide all necessary essentials for living for my behalf, and have done so for a period of _____ years/months.

☐ I am still Homeless. I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

☐ There are no changes to my (or my spouse's) income or household size since my previous application.

_____ _____
Signature Date