Jackson HEALTH SYSTEM
Miracles made daily.

Financial Assistance Application

I. Demograhic Information		
Applicant's Social Security Number:	**Jackson Health Medical Record Number:** (If Applicable or Available)	
Last Name:	**First Name:**	**Middle Name:**
Date of Birth:	**Country of Birth:**	

Citizenship:

□ U. S. Citizen □Lawful □Permanent Resident □Other

Marital Status: □Single □Married □Separated □Divorce □Widowed

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Are you a current resident of Miami Dade County? Yes □ or No □

Have you lived in Miami Dade County for 90 days or more? Yes □ or No □

Current Living Address: _____

City: _____ County: _____ State: _____

Mailing Address (If different from Living Address):

_____

City: _____ County: _____ State: _____

Home Telephone Number: _____Cell phone Number: _____

Email Address: _____

Emergency Contact _____
Relationship:_____

Emergency Contact Phone Number: _____

Are you a current resident of Miami Dade County? Yes □ or No □

Jackson HEALTH SYSTEM PUBLIC HEALTH TRUST
Miracles made daily.

I. Consent to Verify Employment, Credit History, and Other Financial Information

A. I authorize Jackson Health System to obtain verification of my employment, credit history, and any other financial information, e.g. bank statements, annuities, etc., for purpose of determining eligibility and continuity for charity, grant, and other available government benefit programs.

B. I certify that the information provided to complete this application is true. Additionally, I understand that in accordance with statute 817.50 that providing false information to defraud a hospital for the purpose of obtaining goods and services, including pharmacy items, is a misdemeanor in the second degree.

C. Consent to Email or Text Communications: By my consent below, I authorize the use of any email address or cellular telephone number I provide for receiving information relating to discharge instructions, other healthcare communications, and my financial obligations, including but not limited to: post-operative instructions, physician follow-up instructions, dietary information, prescription information, appointment reminders, payment reminders, patient portal, and links to billing information.

May we contact you via email? ☐ **Yes** ☐ **No**

May we contact you via text communications? ☐ **Yes** ☐ **No**

_____

Applicant's Signature

_____

Date

***Please include supporting documentation (Identification, proof of income, proof of residency, and any other health care coverage documentation) with your application submission.**