Jackson HEALTH SYSTEM
Miracles made daily.

Financial Assistance Application

Financial Assistance Overview

The information requested in this application is required to determine eligibility for financial assistance at Jackson Health System. This financial assistance program is for uninsured patients who have received hospital services. Eligibility is based on a patient's household income as compared to federal poverty guidelines.

Requirements to Apply for Financial Assistance

To be considered for financial assistance:

- the patient must be uninsured
- the patient must be ineligible for other programs, such as Medicaid, or have been rejected for coverage from such programs
- the patient must fully cooperate with the financial assistance review process.
- the patient must provide current proof of income and household size.
- information requested must be received by the specified deadline else patient may not be eligible for FA

Certain financial assistance programs may be limited to Miami-Dade County residents only. Patients are expected to fully cooperate in the financial assistance review process or else may be declined.

What to Expect: The Eligibility Review Process

Once the application is fully received by Jackson staff, eligibility will be determined within 14 days. Current proof of income and household size within 30 days is required. Once the eligibility review is completed and approved, qualifying accounts will be updated accordingly.

Please complete all three pages of this form. Filling out this form completely will help to prevent delays in the review process.

Patient Information			
Patient Name	Social Security#	Date of Birth	Account#

Applicant Information					
Applicant Name		Relationship to Patient	Social Security#	Date of Birth	Marital Status
Address			City, State and Zip Code		
Phone# Mobile: Home:	Email address:	Emergency Contact Name		Emergency Contact Phone#	
Employer Name		Employer Address		Work Phone	

Mailing Address, if different from where applicant lives	City, State and Zip Code

Please list all household members below				
	Name	Social Security Number	Date of Birth	Relationship to Patient
1				
2				
3				
4				
5				
6				

NOTE: please list any additional members of the household in the 'notes' section on page 3 of this form

Monthly Household Income		
Type of Income	Monthly Gross Income for Applicant	Monthly Gross Income for Applicant's Spouse
Employment Income	$	$
Retirement/Pension/Social Security Retirement	$	$
Social Security Disability Income	$	$
Unemployment Income	$	$
Child Support/Alimony	$	$
Other (list source here _____)	$	$

Statement of Support

I certify that I have been unemployed for the last _____ years / _____ months. As a result of being unemployed, I receive food, shelter and clothes from _____ (relationship to applicant = _____)

Acknowledgement and Signatures

I hereby certify that the information provided in this application is true, accurate and complete to the best of my knowledge. I hereby authorize the Hospital to contact any person, firm or organization to verify any of the information given and I hereby authorize any such person, firm or organization to release to the Hospital any financial information it may request.

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 Signature Date

Mail Completed Application to:
Jackson Health System
Financial Assessment Department
ACC West 127/Cost Code 93611
1611 NW 12th Ave
Miami, FL 33136

Notes