Miami Jewish Health

FINANCIAL ASSISTANCE APPLICATION

Miami Jewish Health's Financial Assistance Program helps people who are unable to pay all of their hospital medical bills. You may qualify for discounts on medical care through the Program if:

- You do not have health insurance
- Your health insurance does not cover all of the medical care you need
- You are not eligible for Medicaid or some other type of insurance
- You meet the financial criteria

Application Completed by:_____ Date:_____

Please mark line **N/A** if non-applicable

Patient Name: _____ DOB: ____/____/____

Address: _____ Patient Income: $_____per____

_____ Spouse Income: $_____per____

Spouse/Guardian Name: _____ Income Type:_____

Phone #: Home (_____)_____ Cell (_____)_____

Responsible Person: _____ Citizenship (please check)

Employer: _____ U.S. Citizen Y / N

Spouse/Employer: _____ Immigrant/non-citizen _____

Number of members in the family: _____ Non immigrant Visa Holder_____

Other _____

Other income, including SSI/Social Security/Child Support payments:

Who receives the income:_____ Source:_____

Gross Amount $_____ per____

Please check the appropriate statement boxes. Attach copies of DCF notice including attachments

MEDICAID STATEMENT

1. I/We [ ] have / [ ] have not applied for Medicaid to cover these services.
If not, please explain reason:_____
2. I/We [ ] have / [ ] have not been rejected by Medicaid
Reason for reject: Include a copy _____
3. I/We received an approval from Medicaid, but with a monthly spend down of $_____

I understand that this application for Financial Assistance is confidential and will be used to determine my eligibility for uncompensated services under the Financial Assistance guidelines established by Miami Jewish Health. If any information that has been given proves to be untrue, I understand that Miami Jewish Health may re-evaluate my financial status and take whatever action becomes appropriate.

Signature of responsible party: _____ Date: _____

PLEASE PROVIDE PHOTO ID OR OTHER LEGAL IDENTIFICATION PLUS ONE OF THE FOLLOWING DOCUMENTS:

Last 3 consecutive paystubs — Most recent Tax Return — Most recent Social Security Statement

RETURN TO:
MIAMI JEWISH HEALTH
ATTN: ADMISSIONS DEPARTMENT
5200 NE 2ND AVE
MIAMI, FLORIDA 33137

2020 Charity Care Schedule

Charity Care % Allowance	Household Size	% of FPL	One Person	Two People	Three People	Four People	Five People	Six People
	FPL - Annual Gross Income		12,490	16,910	21,330	25,750	30,170	34,590
	Monthly Gross Income		1,041	1,409	1,778	2,146	2,514	2,883
100%		Up to 200%	24,980	33,820	42,660	51,500	60,340	69,180
			2,082	2,818	3,555	4,292	5,028	5,765
80%		201 to 250%	31,225	39,825	50,225	60,625	71,025	81,425
			2,602	3,319	4,185	5,052	5,919	6,785
60%		251 to 300%	37,470	50,730	63,990	77,250	90,510	103,770
			3,123	4,228	5,333	6,438	7,543	8,648
40%		301 to 350%	43,715	59,185	74,655	90,125	105,595	121,065
			3,643	4,932	6,221	7,510	8,800	10,089
20%		351 to 400%	49,960	67,640	85,320	103,000	120,680	138,360
			4,163	5,637	7,110	8,583	10,057	11,530
0%		401% and ove						

For Office Use Only

Date Received in Business Office: _____/_____/_____ By:_____

Approved By: _____ Rejected By:_____

Reason:_____

Applicant advised on _____/_____/_____ by [ ] phone [ ] letter [ ] in person

An account for $_____ for_____payments established