SAMPLE - FICTIONAL DATA · Filled by BillRadar for a demo. Not a real application.

MEMORIAL HEALTHCARE SYSTEM
Financial Evaluation Form

Account Number	MR Number
5057388228	

Patient's Name: Daniela Castillo
Street Address: 9349 Seagrape Ln Apt 717 Telephone#: (954) 555-0161
City: Bayside State: FL Zip: 33067

Please provide the following information completely and accurately. Information is subject to verification. ***In accordance with Florida Statute Section 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second (2nd) degree.***

List of household Members	Date of Birth	Relationship to Patient	Employer
Daniela Castillo	04/17/1994	Self	Harbor Point Dental Studio
Adrian James Castillo	02/11/2025	Son	

Monthly Income		Monthly Expenses	
Responsible Party's Gross Salary	$ 4,833.33	Rent or Own	$
Spouse's Gross Salary	$	Electricity	$
Other Income:	$	Phone	$

Assets	
Checking Account	$
Savings/Money Market/CD's	$
Value of Residences(s)	$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through the South Broward Hospital District d/b/a Memorial Healthcare System. If I am entitled to any action against or settlement from third party payors, I will take any action necessary or requested by Memorial Healthcare System to obtain such assistance and will assign to Memorial Healthcare System, and upon receipt will pay to Memorial Healthcare System, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Memorial Healthcare System will result in the denial of this application. I also authorize Memorial Healthcare System to check my credit history through the credit bureau, if deemed appropriate.

Signature of Patient (Responsible Party) Date

[Label]

Witness Date

2310-10040 (5-19)

Rules: the public Financial Assistance Policy and form of Memorial Regional Hospital (FL; MHS = Memorial Healthcare System), applied to the fictional Seaside Regional Hospital case.

TABLE C

SECTION 1: IDENTIFICATION

Please provide **ONE** of the following:

- ☐ Current Florida ID
- ☐ Current Driver's License
- ☐ For applicants not eligible to obtain a Florida ID: an alternative government-issued ID must be provided

SECTION 2: ELIGIBILITY

If you are a US citizen or legal resident for 5 years or more
AND you are 65 years or older, **OR** receiving disability benefits, **OR** have any dependents children under 18 years old in your household, you MUST provide **ONE** of the following documents:

- ☐ Proof of Medicaid Application **prior** to applying for this program
- ☐ Medicaid Denial Letter

PROOF OF RESIDENCE

The following documents **MUST** be addressed to **you or your spouse:**

SECTION 2A

Please provide **ONE** of the following:

- ☐ Current FPL bill
- ☐ Current Water/Sewer bill
- ☐ Current Home Phone bill
- ☐ Current Cable bill
- ☐ Current Internet bill
- ☐ Current Satellite TV bill

AND **ONE** of the following:

- ☐ Current Mortgage Statement
- ☐ Homestead Exemption
- ☐ Property Tax Statement
- ☐ Property Deed
- ☐ Lease Agreement*
- ☐ Current Auto Registration
- ☐ Notarized Proof of Address
- ☐ Sublet Lease Agreement

*If the lease agreement states that the utilities are included in the rent, two pieces of business or government correspondence addressed to you are required in addition to the lease agreement

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If SECTION 2A is completed, you may skip SECTION 2B and 2C and continue to SECTION 3 and 4.
If you are unable to submit the TWO documents from SECTION 2A, you MUST complete SECTION 2B and 2C first.

SECTION 2B

If you sublet or rent a room, or do not pay for your own living arrangements, you MUST provide **TWO** of the following. The documents must not be more than 90 days (3 months) old:

- ☐ Business Correspondence: Credit card statement, Bank statements, Car loan statement, Any personal bill
- ☐ Government Correspondence: Food Stamps letter
- ☐ Declaration of Domicile form from the Broward County Governmental Center
- ☐ Proof of Rent Payments
- ☐ School Schedule

SECTION 2C

If you do not pay for your living arrangements, you MUST provide **ALL** of the following in addition to the documents listed in SECTION 3B:

- ☐ A Notarized Letter of Support from the person who is helping OR a Notarized Homeless Affidavit from a South Broward District Homeless Shelter (Letter must not be older than 30 days)
- ☐ Proof that you are the child, parent or sibling of the supporter OR that the supporter claims you for federal income tax purposes OR Proof of enrollment in an appropriate, recognized, social service program for the homeless in the South Broward District

☐ For applicants providing a Letter of Support: a copy of your supporter's photo ID must also be provided

SECTION 3: PROOF OF CITIZENSHIP/ IMMIGRATION STATUS

Non-citizens and visitors:
MUST provide **ONE** of the following for each member of the household:

- ☐ Work Authorization card
- ☐ Proof of residence in South Broward County
- ☐ Florida ID or Social Security card
- ☐ Passport with Visa and I-94
- ☐ Resident card

SECTION 4: PROOF OF INCOME

Legally married or unmarried partners with children **MUST** provide income for all family members

Please provide **ONE** of the following:

- ☐ Paycheck stubs showing gross income for the last 6 weeks for you, your spouse or domestic partner and all family members
- ☐ A dated letter from your employer, on company letterhead, stating hours worked and gross pay
- ☐ For self-employed applicants: a completed Declaration of Income Form may be accepted

Please provide **ALL** that apply:

- ☐ Aid to Family with Dependent Children
- ☐ Alimony
- ☐ Child Support
- ☐ Disability Income
- ☐ Social Security Income
- ☐ Unemployment Compensation
- ☐ Pensions
- ☐ Dividend Income
- ☐ Annuities
- ☐ Worker's Comp

Please provide **ONE** of the following:

- ☐ Last 3 consecutive statements for ALL personal (checking, savings, IRAs, CDs, money market, and bonds) AND business bank accounts for you, your spouse (or Domestic Partner), and dependents
- ☐ Applicant and/or supporter's proof of payment for all monthly expenses for the last 3 months (i.e., money orders, cash receipts, cancelled checks)

Please provide **ONE** of the following:
All pages must be provided including 1040 forms, W-2 forms, 1099's and all schedules

- ☐ Current income tax return – if filing separately, both Tax Returns must be provided **(all forms /pages)**
- ☐ Personal and business income tax returns for you, your spouse, and all other family members **(all forms /pages)**
- ☐ 4506-T Form: Request for Transcript of Tax Return **(Call IRS at 1-800-908-9946 for free copy of transcripts)**
- ☐ If you are self-employed, you MUST provide the entire Income Tax Return form. **(all forms /pages)**

Non-citizens and visitors:
Please provide the following:

- ☐ Proof of payment for travel to US
- ☐ Proof of income/expenses from country of origin
- ☐ Proof of support while in the US
- ☐ US sponsor

Additional information/documentation may be requested to complete your application. All information is subject to verification.
For additional eligibility questions, please contact Customer Service at (954) 276 5501.