FLORIDA
REHABILITATION HOSPITAL
at TAMPA

Financial Assistance Application Form

PATIENT NAMEIN FULL			M F	AGE	DATE OF BIRTH
ARE YOU A CITIZEN OF THE UNITED STATES ☐ Yes ☐ No	RESIDENT OF OKLAHOMA ☐ Yes ☐ No	HAVE YOU APPLIED FOR MEDICAL ASSISTANCE (MEDICAID) ☐ Yes ☐ No		IF YES, INDICATE MONTH	YEAR
AREYOUORYOURSPOUSESELF-EMPLOYED ☐ Yes ☐ No	DID YOU FILE A FEDERAL TAX RETURN ☐ Yes ☐ No	STATE TAXRETURN ☐ Yes ☐ No	DO YOU HAVE THIRD-PARTY INSURANCE COVERAGE ☐ Yes ☐ No		

RESPONSIBLE PARTY INFORMATION

APPLICANT		APPLICANT'S SPOUSE		
NAME		NAME		
ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER ( )	CELL PHONE ( )	PHONE NUMBER ( )	CELL PHONE ( )	
SOCIAL SECURITY NUMBER		SOCIAL SECURITY NUMBER		
EMPLOYER		EMPLOYER		
IF UNEMPLOYED, LAST DATE WORKED		IF UNEMPLOYED, LAST DATE WORKED		
DATE LAST CHECK RECEIVED		DATE LAST CHECK RECEIVED		

FAMILY AND PATIENT INFORMATION

FAMILY MEMBERS LIVING IN THE HOME

NAME	DATE OF BIRTH	AGE	RELATIONSHIP	SOCIAL SECURITY NUMBER

FAMILY INCOME
List Amounts ofEach

Patient	SALARY / WAGES / TIPS	INTEREST / DIVIDENDS	ALIMONY	SOCIAL SECURITY	PENSION / RETIREMENT
Patient	DISABILITY	UNEMPLOYMENT	WORKERS COMP	SELF EMPLOYMENT - ATTACH SCHEDULE C	
Spouse	SALARY / WAGES / TIPS	INTEREST / DIVIDENDS	ALIMONY	SOCIAL SECURITY	PENSION / RETIREMENT
Spouse	DISABILITY	UNEMPLOYMENT	WORKERS COMP	SELF EMPLOYMENT - ATTACH SCHEDULE C	

FAMILY RESOURCES

Checking Account(s)		
Savings Account(s)		
IRA / 401K / 430B		
Food Stamps (list amount received)	WIC ☐ No ☐ Yes (Need Qualifying Letter)	LOW INCOME HOUSING ☐ No ☐ Yes (Need Qualifying Letter)
PROPERTY (HOUSE OR PERSONAL PROPERTY OTHER THAN YOUR RESIDENCE) - *DESCRIPTION AND LOCATION*	MARKET VALUE $	
ISTHISHOSPITALSERVICE/PHYSICIANSERVICEARESULTOFAPERSONALINJURY/ACCIDENTCASEFROMWHICH YOU EXPECT TO RECEIVE ASETTLEMENT ☐ Yes ☐ No	IF YES, EXPECTED AMOUNT $	

I hereby acknowledge that I have read this document. It has been provided in printed format or explained to me in my native language and was understood. I certify that all information regarding income and assets are true. I understand that the information which I submit concerning my income, assets, liabilities, and family size is subject to verification. I hereby authorize the release of any necessary information from individuals, universities or colleges, businesses, public or private organizations to determine my eligibility. I assign and transfer to Reunion Rehabilitation Hospital Jacksonville all my rights to benefits, monies, and sums payable to me for hospitalization, sickness, or accident liability coverage. I understand that failure to disclose information and/or payments will result in denial of the application.

PATIENT - SIGNATURE		DATE	TIME
PERSON COMPLETING FORM, IF OTHER THAN PATIENT - SIGNATURE	RELATIONSHIP TO PATIENT	DATE	TIME

INTERPRETER / WITNESS - SIGNATURE

DATE TIME

PATIENT LABEL

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