TALLAHASSEE MEMORIAL HEALTHCARE

Application for Assistance with Hospital Expenses

It is the policy of Tallahassee Memorial Hospital to provide financial assistance and counseling for uninsured and under-insured people, without regard to race, ethnicity, gender, religion or national origin.

We have identified your account as a possible candidate for financial assistance. If qualified, you would not be responsible for payment of this account. In order to begin the process, we ask that you complete this form by circling the number of people in your family **AND** the total household income:

Family Members	Household Income	Family Members	Household Income
1	0 – $ 18,735	5	0 – $ 45,255
2	0 – $ 25,365	6	0 – $ 51,885
3	0 – $ 31,995	7	0 – $ 58,515
4	0 – $ 38,625	8	0 – $ 65,145

(For each additional family member add $6,630.)

Please note: In the case of a catastrophic event, you may be eligible for assistance even if your income is more than listed above.

We also need you to provide the following information:

1. **Proof of income** –The financial information you provide will be verified by TMH. Please provide this information for ALL household income.

   Acceptable forms of proof of income include:

   - Six pay statements (most recent)
   - 2018 Tax Return (Required if self employed ONLY)
   - Unemployment Statement
   - Financial Aid Award Letter
   - Bank Statements (direct deposit)
   - Retirement/Pension/VA Benefits Statements
   - Social Security/Disability
   - Child Support/Alimony Statements

W2s ARE NOT ACCEPTED AS PROOF OF INCOME

2. **Statement of Residency Form** (enclosed) - if someone else is providing you with food, housing or financial assistance. ****THIS FORM MUST BE NOTARIZED****
3. **Homeless Affidavit** (enclosed) - if you are homeless.

All paperwork must be returned within 10 days of receipt.

Missing or incomplete information could cause your application to be delayed or denied. Be mindful that financial assistance applications are reviewed monthly, so you will receive bills until a decision has been made. Falsification of this information is against state law and will result in a denial for assistance.

As the holder of the Assignment of Benefits, Tallahassee Memorial Hospital is entitled to be reimbursed from any settlement/judgment proceeds resulting from a third party liability. Any assistance provided will be revoked for failure to advise TMH of a settlement/judgment, making the total balance your responsibility.

THIS APPLICATION ONLY COVERS THE FACILITY CHARGES PROVIDED AT TALLAHASSEE MEMORIAL HOSPITAL.

I understand that providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree and punishable under Florida Statute 817.50. I certify the above information is true and accurate to the best of my knowledge.

Date _____ Signature of Patient or Guardian _____

Date _____ Witness to Signature _____

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