

Admit Date: _____ HAR #: _____ Telephone#: _____ Date of Birth: _____
 Patient Name: _____ Social Security #: _____ Marital Status: S M D X W
 Physical Address: _____ Mailing Address: _____

HOUSEHOLD COMPOSITION (PERSON/PERSONS LIVING AT HOME)

NAME (Last, First, Middle)	SEX	AGE	DOB	RELATIONSHIP	ANNUAL INCOME

ANNUAL INCOME INFORMATION (PREVIOUS 12 MONTHS FROM DATE OF ADMISSION)

#1 PATIENT/GUAR EMPLOYER (current): _____ **LENGTH OF EMPLOYMENT:** _____ **Phone#:** _____
If employed < 12 months, must complete section #2
 Gross wages: _____ Hourly Weekly Monthly Yearly Number of hours per week: _____
 Do you own the business?: Yes No If Yes, please provide personal & business Tax Returns.

#2 EMPLOYER (previous/past): _____ **LENGTH OF EMPLOYMENT:** _____ **Phone#:** _____
 Gross wages: _____ Hourly Weekly Monthly Yearly Number of hours per week: _____

#3 SPOUSE/SIG. OTHER EMPLOYER (current): _____ **LENGTH OF EMPLOYMENT:** _____ **Phone#:** _____
If < 12 months, must complete section #4
 Gross wages: _____ Hourly Weekly Monthly Yearly Number of hours per week: _____
 Do you own the business?: Yes No If Yes, please provide personal & business Tax Returns.

#4 EMPLOYER (previous/past): _____ **LENGTH OF EMPLOYMENT:** _____ **Phone#:** _____
 Gross wages: _____ Hourly Weekly Monthly Yearly Number of hours per week: _____

Retirement benefits: Yes No Amount \$: _____ Unemployment: Yes No Amount \$: _____
 Disability benefits: Yes No Amount \$: _____ Rental Income: Yes No Amount \$: _____
 Other Household Income Yes No Amount \$: _____ SS benefits: Yes No Amount \$: _____
 VA? Yes No Amount \$: _____ IRA's? Yes No Amount \$: _____

ASSET INFORMATION

Name of Bank: _____ Checking: \$ _____ Savings: \$ _____ Money Mkt: \$ _____
 Stocks? Yes No \$ _____ Bonds? Yes No \$ _____ CD's Yes No \$ _____
 Home: Own? Yes No Rent: Yes No Buying Yes No What is monthly payment? \$ _____
 Do you own other property: Yes No If Yes, what is the location? _____
 Vehicle 1 Year: _____ Make: _____ Balance owed or monthly payment: \$ _____
 Vehicle 2 Year: _____ Make: _____ Balance owed or monthly payment: \$ _____
 Vehicle 3 Year: _____ Make: _____ Balance owed or monthly payment: \$ _____

MEDICAID/AFFORDABLE CARE ACT (ACA) QUESTIONNAIRE

Have you ever applied for Medicaid/ACA? Yes No When: _____ Where: _____
 Comments: _____

COMBINED GROSS INCOME FOR THE PAST 12 (TWELVE) MONTHS HAS BEEN \$ _____ AND THERE ARE _____ (# OF) PEOPLE IN MY FAMILY. THE INCOME INFORMATION CAN BE VERIFIED BY CALLING THE ABOVE EMPLOYERS. ADDITIONALLY, I UNDERSTAND THAT IN ACCORDANCE WITH FLORIDA STATUTES 817.50, PROVIDING FALSE INFORMATION TO DEFRAUD A HOSPITAL FOR THE PURPOSES OF OBTAINING GOODS OR SERVICES IS A MISDEMEANOR IN THE SECOND DEGREE. FURTHER, THE UNDERSIGNED HEREBY CONSENTS TO THE HOSPITAL'S INQUIRIES INTO HIS/HER CREDIT HISTORY IN CONFORMITY WITH THE LEGITIMATE BUSINESS NEEDS AND APPLICABLE LAWS, RULES, AND REGULATIONS.

IN THE EVENT THAT ASSETS OR A PAYMENT BECOME AVAILABLE, LEE HEALTH RESERVES THE RIGHT TO REVERSE THE ORIGINAL ADJUSTMENT.
 LEE HEALTH MAY REQUEST ADDITIONAL DOCUMENTS IN SUPPORT OF THIS APPLICATION, AS DESCRIBED IN THE FINANCIAL ASSISTANCE POLICY.

I HEREBY CERTIFY THE ABOVE INFORMATION TO BE TRUE AND CORRECT.

**Copies of the Lee Health Financial Assistance Policy and additional information are available at www.LeeHealth.org.
 If you have any questions or need help, Financial Counselors are available at 800-809-9906**

 Patient/Guarantors Signature Date Witness Signature

 Spouse Signature Date