

PATIENT FINANCIAL HARDSHIP ASSISTANCE APPLICATION

Baptist Medical Park Surgery Center, LLC, abides by the contractual and legal obligations of health benefit plans to collect patients out-of-pocket expenses assigned by the payers. The out-of-pocket expenses include copays, coinsurance and deductibles.

Recognizing that circumstances may arise where an individual is unable to meet financial obligations, we have adopted a screening process for patients who may qualify for financial hardship assistance. This application must be completed by the assigned due date below.

Application due: _____

Return application and documents to:

Baptist Medical Park Surgery Center, LLC
c/o Manager of Business Operations
9400 University Parkway, Suite 102
Pensacola, FL 32514

To do this, we must ask for certain financial information. *All information will be held confidential according to our privacy policy.*

Please provide the documents listed below for each adult family member, and complete this form to the best of your ability:

- A copy of last year's federal tax return;
- Copies of the two most recent payroll stubs or unemployment benefit payments;
- If income is close to or below the poverty level, documentation that states medical assistance has been applied for and denied.

Applicant's name: _____ Date of birth: _____

Patient name (if different from applicant): _____ Patient date of birth: _____

Number of dependents in household: _____ Number in school: _____

Primary phone #: _____ Email: _____

Type of assistance requested: Discounted cash payment Extended payment plan Debt forgiveness

Employment/unemployment information (for each adult family member):

Name: _____ Employer: _____

Address: _____

Phone: _____

Name: _____ Employer: _____

Address: _____

Phone: _____

If unemployed, please state when employment was terminated. If layoff is temporary, indicate expected duration: _____

Assistance received: State financial assistance WIC Food stamps

PROPERTY/INVESTMENT VALUES

	Address or description	Value
Home		\$
Other real estate owned		\$
Land		\$
Business		\$
Livestock		\$
Savings/stocks/bonds		\$
Other investments		\$

Notes: _____

Please complete the information in the following table based on average income and expenses over the last 12 months. For amounts paid annually, enter annual amount divided by 12.

HOUSEHOLD FINANCIAL INFORMATION

Monthly income (after payroll deductions)		Monthly expenses (not including payroll deductions)	
Employment	\$	Mortgage/rent	\$
Unemployment/severance	\$	Auto/transportation	\$
Self-employment	\$	Non-reimbursed work expenses (e.g., parking, tools)	\$
Interest/dividends	\$	Insurance (e.g., life, homeowners)	\$
Pension/disability	\$	Utilities (e.g., lights, water, gas)	\$
Child support/alimony	\$	Medications	\$
Short-term disability	\$	Childcare	\$
Long-term disability	\$	Credit cards	\$
Rental income	\$	Child support/alimony	\$
Other income:	\$	Personal property taxes (home, auto)	\$
	\$	Other expenses:	\$
	\$		\$
Total average income	\$	Total average expenses	\$

By my signature below, I certify that this information is true and complete. I grant Baptist Medical Park Surgery Center, LLC, permission to verify the information, and I acknowledge that completion of this form does not guarantee approval of financial hardship.

Applicants Signature	Printed Name	Date
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Reviewed by:

Reviewers Signature	Printed Name	Date
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Approved by:

Signature	Printed Name	Date
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