



# Financial Assistance Application Form

## SECTION ONE: PATIENT INFORMATION

Print your full name, your address at the time you received medical service and other information noted in this section.

Account Number \_\_\_\_\_ Date(s) of Service \_\_\_\_\_

Patient Name: \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_  
NUMBER AND STREET

State of Residence: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status:  Single  Married  Divorced

Primary Phone Number: (\_\_\_\_) \_\_\_\_\_  Home  Mobile  Work  Other \_\_\_\_\_

Email Address: \_\_\_\_\_

Health insurance at time of date of service:  No Insurance  Medicare  Medicaid  Other \_\_\_\_\_

## SECTION TWO: FAMILY INCOME AND ASSETS

Provide income for yourself, your spouse and all other family members (if applicable).

Income Source	Total for 3 Months Prior to Service	Total for 12 Months Prior to Service
Wages/Self Employment	\$ _____	\$ _____
Social Security	\$ _____	\$ _____
Pension, Dividends, Interest, Rental Income	\$ _____	\$ _____
Unemployment, Workers' Compensation	\$ _____	\$ _____
Child Support (only if the patient is the intended recipient)	\$ _____	\$ _____
Other	\$ _____	\$ _____

Total Net Assets (Assets - Debt) as if the Date of Application: \$ \_\_\_\_\_

## SECTION THREE: FAMILY INFORMATION AND INCOME

List all family members in your household and their date of birth.

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of HCAP, family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Name of family members, including patient	Date of Birth	Relationship to Patient
1. Patient: _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

By my signing below, I certify that everything I have stated on this application and on any attachments is true.

Responsible Party Signature: x \_\_\_\_\_ Date: \_\_\_\_\_

Return your completed application to: [Select Specialty Hospital - Gainesville](#)

1600 SW Archer Road, 5th Floor Gainesville FL 32610

(352) 265-0055

Rev. 11/2019