Lake Shore Hospital Authority
FINANCIAL ASSISTANCE APPLICATION

Office Hours M-F 8:30-4:30
Phone (386)755-1090
Fax (386) 755-7009
www.lakeshoreha.org

We take the last applicant at 4:00

APPLICANT NAME:____
Last First MI Maiden or Other Name

PHYSICAL ADDRESS____(where you reside)

CITY________________________________COUNTY_______________STATE______ZIP__________

TELEPHONE: Home______________ CELL: ______________ DATE OF BIRTH__________ S.S. #_______________

SPOUSE'S NAME: ____
Last First MI

DATE OF BIRTH______________________ S.S. #___________________

APPLICANT'S EMPLOYER NAME____

APPLICANT'S EMPLOYER'S PHONE NUMBER____________________ HOW LONG__________MOS/YRS (circle one)

RATE OF PAY__________________HOURLY, DAILY, WEEKLY, BI-WEEKLY, MONTHLY (CIRCLE ONE)

SPOUSE'S EMPLOYER NAME____

SPOUSE'S EMPLOYER'S PHONE NUMBER______________________ HOW LONG__________MOS/YRS (circle one)

RATE OF PAY__________________HOURLY, DAILY, WEEKLY, BI-WEEKLY, MONTHLY (CIRCLE ONE)

OTHER SOURCES OF INCOME: Child Support/Alimony_______Rental Income_____SS/SSI_______ Odd jobs _______
Retire/Pension_________Welfare/AFDC_____U/C_____Interest/Dividends______Other_____Food Stamps_______

EXPENSES: Monthly Rent/Mortgage_________Land Pymt________Electric______Water______Gas/Sewer_____
Telephone Pmyt. __________ Cable Pymt. _______ Vehicle Pymt ___________
Gas/mo___________Insur/mo____________Child Support_________

PROPERTY OWNED: List all real estate owned, co-owned, or that applicant's name is associated with.
Location Address

1.____Lien Amount___________ Lien Holder_____________
2.____Lien Amount___________ Lien Holder_____________

BANK ACCOUNTS: List all bank accounts in applicant's name or that applicant's name is associated with, such as, checking accounts, savings accounts, or certificates of deposit.

Name of Bank

1.__________________________Type of Account ____________Account Balance_______________

2.__________________________Type of Account ____________Account Balance_______________

See Back of Application to Complete

Revised June 12, 2017

MOTOR VEHICLES: List all automobiles, boats, motorcycles, motor homes, travel trailers, owned, co-owned.

YEAR	MODEL	VIN#	MO. PAYMENT	LIEN HOLDER	LOAN AMT

List all members of the family unit (including all children under age of 18 for who you are a legal guardian, provide support and claim on taxes.

Name	DOB	Relationship	SS#

List all sources of income for the family unit

Name	Type of Income	Source of Income Or Employer	Monthly Amount (before deductions)

Authorization to Release Medical and Individually-Identifiable Protected Health Information (PHI)

I, on my behalf and on behalf of any applying family member under the age of 18, do hereby authorize Lake Shore Hospital Authority (LSHA), Shands Lake Shore Regional Medical Center and any of their participating providers to release and exchange any and all data, records and information related to medical records and individually identifiable protected health information (PHI) in their respective capacities as covered entities under HIPAA, and as allowable under federal and state laws, including but not limited to the data, records and information as necessary to provide care and/or administer the LSHA Indigent Health Care Program.

I hereby waive, relinquish and release the organizations referenced above, who have been granted the authority to release information to each other and otherwise, from any and all claims arising out of my authorization to release this information in accordance with the terms of this document.

A photocopy of this Authorization is considered as valid as the original. You are entitled to make and return a photocopy of this authorization. The authorization referenced above in regards to medical records shall remain in effect indefinitely unless properly terminated by written notice.

Signature of Individual or Legal
Representative:____Date

Applicant's Declarations and Authorizations

I certify that the information given by me for the purpose of qualifying for the LSHA Financial Assistance Program is true and accurate to the best of my knowledge, and that I have no other income, assets or liabilities except those listed. I understand that any misrepresentation by evidence of submission or omission may result in my termination from the LSHA Financial Assistance Program as well as **constitute fraud in violation of 817.50 Florida Statutes**. I authorize Lake Shore Hospital Authority, including its Trustees, employees, representatives, and agents, to use this information and make inquiries or obtain any information necessary to verify the accuracy of the information contained herein. I authorize all financial institutions, the Social Security office, the Credit Bureau, my creditors, landlord, and past and present employers to release any information or documentation requested by the Lake Shore Hospital Authority to verify the information provided herein and for such other purposes deemed necessary by LSHA to verify my qualifications for healthcare services.

Signature of Individual or Legal
Representative:____Date

LSHA Member Responsibility Statement

I certify that as a member of the LSHA Financial Assistance Program I will keep my appointments, call to cancel if I cannot keep them, arrive on time, and treat office staff and physicians with respect. When given prescriptions, I will seek assistance if needed and strive to stay in compliance with my medications. If I abuse/misuse the Financial Assistance Program benefits, I understand that I can be terminated immediately.

Signature of Individual or legal
Representative:____Date

Lake Shore Hospital Authority
Financial Assistance Program ID card

VERIFICATION OF SUPPORT

Patient Name:____

Patient DOB:____________________SS # Last 4 digits_______________

To be completed by applicant

I,_______________________________________declare that I am presently unemployed and have been unemployed for_____months. I have received $______in income for the last 12 months. I have/have not (circle one) applied for unemployment benefits. I am presently residing at

____.

I have been residing at the above address since______________. My previous address was

____. My food and living expenses are provided

by____.

Patient Signature____

Date_______________________________________

Revised 1/3/12

To be completed by Provider

Total household expenses____
Total number of adults in household__________________________________
Amount of support provided to applicant______________________________
Provider Name____
Address____
____Phone______________

I, the undersigned, being responsible for the named applicant, do hereby swear that the information contained herein is true and correct, and that I am providing support for named applicant.

Signed by:____________________________________

Signature must be notarized

STATE OF FLORIDA

COUNTY OF ________________

The foregoing instrument was acknowledged before me this__________day of_______, 20____, by

_____________________________.

____
Signature of Notary Public – State of Florida

Personally known_______OR

Produced Identification______

Type of Identification Produced______________________

Revised 1/3/12