LAKE SHORE HOSPITAL AUTHORITY
FINANCIAL ASSISTANCE PROGRAM
www.lakeshoreha.org
PHONE: 386-755-1090
FAX: 386-755-7009
LSHA office hours are M-F 8:30-4:30
We take our LAST applications by 4:00

**** You MUST be a resident of Columbia County for 12 months+. Please refer to Financial Assistance Checklist for necessary documents.**

**** Application MUST be complete or it will NOT be accepted. (please fill in ALL blanks, if it does not apply put a 0 or an N/A in the blank-leave no blank spaces)**

**** If Rent Verification or Support Verification applies to your situation, it MUST be included.**

**** Please return application within 90 days ****

Lake Shore Hospital Authority
FINANCIAL ASSISTANCE APPLICATION

APPLICANT NAME:_____
Last First MI Maiden or Other Name
PHYSICAL ADDRESS_____ (where you reside)

CITY_____COUNTY_____STATE_____ZIP_____

How long have you lived at current residence_____Temp/Perm_____Rent/Own/Other_____

Previous address if less than 3 months_____

MAILING ADDRESS_____
CITY COUNTY STATE ZIP
TELEPHONE: Home_____Daytime_____Evening _____Cell_____

DATE OF BIRTH_____ SEX: M F (circle one) S.S. #_____

SPOUSE'S NAME: _____
Last First MI
DATE OF BIRTH_____ SEX: M F (circle one) 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_____Retire/Pension_____

Welfare/AFDC_____U/C_____Interest/Dividends_____Other_____Food Stamps_____

ASSETS: Home Value_____ Balance owed_____Other Real Property Value Worksheet attached Stocks, Bonds_____

Jewelry_____Recreational Vehicles_____Vehicle 1_____Vehicle 2_____Vehicle 3_____

EXPENSES: Monthly Rent/Mortgage_____Land Pymt_____Electric_____Water_____Gas/Sewer_____

Telephone_____Vehicle pymt 1_____Vehicle pymt 2_____Gas/mo_____Insur/mo_____
Home cell
Health insur_____Life insur_____Home Owners_____Child Support/Alimony_____Child Care_____

OTHER EXPENSES/LOANS:_____

_____

Revised 1/3/12

Lake Shore Hospital Authority
ASSETS WORKSHEET

Real Estate: List all real estate owned, co-owned, or that applicant's name is associated with.

LOCATION ADDRESS	LIEN AMOUNT	LIEN HOLDER
1.		
2.		
3.		

Motor Vehicles: List all automobiles, boats, motorcycles, motor homes, travel trailers, and aircraft owned, co-owned or that applicant's name is associated with.

YEAR	MAKE	MODEL	VIN	MO. PAYMENT	LIEN HOLDER	LOAN AMT.

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.

BANKING INSTITUTION	ACCT. #	TYPE OF ACCT.	BALANCE
1.			
2.			
3.			

Have you applied for other aid? Yes No (circle one) If yes, when_____Where_____

Do you or your family have Health Insurance? Yes No (circle one)

If employed, is Health Insurance offered? Yes No (circle one)

(Circle all that apply) MEDICARE MEDICAID OTHER INS. (specify)_____

MEDICAID APPLICATION/CASE NUMBER ***(or copy of denial attached)***

LIST ALL MEMBERS OF THE HOUSEHOLD (including all children under age of 18 for whom you are a legal guardian, provide support and claim on taxes)

Name	***DOB***	***RELATIONSHIP***	***SS#***
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

LIST ALL SOURCES OF INCOME FOR THE HOUSEHOLD

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

CONTINUE TO PAGE (4) FOR SIGNATURE AND AUTHORIZATIONS

LSHA FINANCIAL ASSISTANCE APPLICATION PAGE (4)

APPLICANT NAME_____

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. I will submit to random drug testing if requested by the Lake Shore Hospital Authority. 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_____

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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_____

Lake Shore Hospital Authority
Financial Assistance Program ID card

RENT VERIFICATION

Patient Name_____

Patient D.O.B._____SS # Last 4 digits_____

I,_____(patient) declare that I presently reside at

_____.

The monthly rent is $_____. I began renting at the above location on _____ (date).

Patient Signature_____Date_____

I,_____(rentor/lessor name), certify that I have been renting the above

APARTMENT/ROOM/HOUSE/CAMPER/LAND/MOBILE HOME
(CIRCLE ONE)

to_____ (print patient's name) since_____ (date).

The current monthly rental rate is $_____.The monthly rent does/ does not (circle one) include utilities. If so, list utilities included: _____.

Rentor/Lessor Name_____

Address_____

Phone _____

I, the undersigned, do hereby swear that the information contained herein is true and correct.

Rentor/Lessor Signature **Date**

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