Lake Shore Hospital Authority
MEDICAL ASSISTANCE APPLICATION

Office Hours M-F 8:30-3:30
Phone (386)755-1090
Fax (386) 755-7009
www.lakeshoreha.org

We take last applicant at 3:30 pm

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 NUMER_____ HOW LONG_____MOS/YRS (circle one)

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

SPOUSE'S EMPLOYER NAME_____
APPLICANT'S EMPLOYER'S PHONE NUMER_____ 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

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_____

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#

See Back of Application to Complete

Revised June 12, 2023

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), 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 Medical 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 Medical 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 Medical 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 Medical Assistance Program benefits, I understand that I can be terminated immediately.

Signature of Individual or legal

Representative: _____ Date

Lake Shore Hospital Authority
Medical Assistance Program ID card

VERIFICATION OF SUPPORT

Patient Name:_____

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_____

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.

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_____