DOCTORS' MEMORIAL HOSPITAL

A TALLAHASSEE MEMORIAL HEALTHCARE AFFILIATE

PO BOX 1847 PERRY, FL 32347 Ph.: (850) 584-0800 Fax: (850) 584-2524

Declaration Financial Statement

MR #: _____

In an effort to meet the community's healthcare needs, financial assistance is available to patients/surety (person that is financially responsible) who have limited or no resources to pay for emergent or medically necessary services rendered at Doctors Memorial Health facility (Hospital or Clinic). This Declaration Financial Statement is used to evaluate a patient or surety eligibility for financial assistance provided by Doctors Memorial Hospital. Completed Declaration Financial Statements received within the time frame given by Financial Counselor will be reviewed to determine if you are eligible for financial assistance. This application is for consideration of the hospital only and does not assist with other non-DMH health provided services which you may have received related to your care at Doctors' Memorial Hospital.

_____

(Patient Name) (Patient relationship)

Guarantor Information

Guarantor Name: _____ Date of Birth: _____

SSN/TIN: _____ Marital Status: M S D W

Contact Number: _____ _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

In the past 12 months, have you applied for: (circle all that apply)

Medicaid	Social Security Disability	Workers Compensation	County Medical Assistance	Health Exchange Marketplace	No other Medical Assistance

As further condition of eligibility you must make application for any assistance (Medicare, Medicaid, SLH, Medical insurance, auto insurance, etc.) that may be available for payment of your hospital charge. You must take any action reasonably necessary to obtain such assistance and assign or pay to the hospital the amount recovered for hospital charges. There are no exceptions to this rule.

Household Information

Household:

Family or household member means ***a partner, spouse, a former spouse, a parent or other person who is related by blood or marriage or is or was actually residing with the person.***

Household member	*Relationship to Guarantor*	*Date of Birth*	*Tax Filing Status* *(Individual, Joint, not Filing)*

Household Total of Residents:

Employment/ Income:

Employment/ Income should include Employment, Unemployment Benefits, SSI and all other household income

Who receives the income?	*Type of Payment*	*Amount Monthly*	*How often?*

Household Total Monthly Income:

If you reported $0 income, please provide a brief description of how basic living needs are being met

_____

_____

_____

Income Certification:

I attest all of the information stated above is correct and true and I acknowledge that providing false information in this form may invalidate any or all financial assistance for which I may be consider receiving. In accordance with Florida Statute 817.50 providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree and I attest to the fact that the information given above is accurate. I consent to a credit check via Equifax by Doctors Memorial Hospital. Doctors Memorial Hospital reserves the right to change any decision made in reliance of this form for which there is a subsequent recovery of monies.

_____ _____

Patient/ Guarantor Signature Witness Signature

_____ _____

Date Date