LAKE BUTLER HOSPITAL
PO BOX 748, LAKE BUTLER, FL 32054 (386)496-2323

PLEASE PLACE PATIENT LABEL HERE

APPLICATION FOR FINANCIAL ASSISTANCE

Please fill out packet in its entirety
*** denotes required answer if applicable**
N/A for Not Applicable

** SIGN BELOW ONLY IF YOU ARE DECLINING TO COMPLETE THIS FORM!

BY DECLINING TO COMPLETE THIS PACKET IN IT'S ENTIRETY, YOU ARE ACKNOWLEDGING AND ACCEPTING FULL FINANCIAL RESPONSIBILITY OF THE TOTAL BALANCE DUE ON YOUR LAKE BUTLER HOSPITAL ACCOUNT.

PATIENT / GUARANTOR'S SIGNATURE **DATE**

*** PATIENT INFORMATION:**

LAST NAME: _____ FIRST NAME: _____
DOB: ____/____/____ SEX: _____ SS# (Not required for Sliding Fee Scale): _____
HOME PHONE: _____ CELL PHONE: _____
(Address is not required for Sliding Fee Scale)
ADDRESS: _____
CITY: _____ ZIP CODE: _____
COUNTY PATIENT RESIDES IN: _____
EMPLOYER (if applicable): _____ PHONE: (____) _____

If injury or accident, did this happen at work? YES: _____ NO: _____
If yes, name & phone to contact @ employment: _____

Has patient been hospitalized in the past year? YES: _____ NO: _____

*** GUARANTOR INFORMATION (IF PATIENT IS A MINOR):**

LAST NAME: _____ FIRST NAME: _____
DOB: ____/____/____ SEX: _____ SS# (Not required for Sliding Fee Scale): _____
HOME PHONE: _____ CELL PHONE: _____
(Address is not required for Sliding Fee Scale)
ADDRESS: _____
CITY: _____ ZIP CODE: _____
EMPLOYER (if applicable): _____ PHONE: (____) _____
RELATIONSHIP TO PATIENT: _____

*** SPOUSE INFORMATION:**

LAST NAME: _____ FIRST NAME: _____
DOB: ____/____/____ SEX: _____ SS# (Not required for Sliding Fee Scale): _____
HOME PHONE: _____ CELL PHONE: _____
(Address not required for Sliding Fee Scale)
ADDRESS: _____
CITY: _____ ZIP CODE: _____
EMPLOYER (if applicable): _____ PHONE: (____) _____

*** LIST ALL PERSONS LIVING IN THE HOUSEHOLD:**

NAME:_____ DOB:_____ SEX:___ RELATIONSHIP: ___(SELF)_____

NAME:_____ DOB:_____ SEX:___ RELATIONSHIP: _____

NAME:_____ DOB:_____ SEX:___ RELATIONSHIP: _____

NAME:_____ DOB:_____ SEX:___ RELATIONSHIP: _____

NAME:_____ DOB:_____ SEX:___ RELATIONSHIP: _____

NAME:_____ DOB:_____ SEX:___ RELATIONSHIP: _____

NAME:_____ DOB:_____ SEX:___ RELATIONSHIP: _____

NAME:_____ DOB:_____ SEX:___ RELATIONSHIP: _____

NAME:_____ DOB:_____ SEX:___ RELATIONSHIP: _____

*** MONTHLY INCOME OF ALL WORKING PERSONS IN THE HOUSEHOLD:**

NAME:_____ **GROSS MONTHLY INCOME:** $_____

$_____PER HOUR X _____HOURS PER WEEK

NAME:_____ **GROSS MONTHLY INCOME:** $_____

$_____PER HOUR X _____HOURS PER WEEK

NAME:_____ **GROSS MONTHLY INCOME:** $_____

$_____PER HOUR X _____HOURS PER WEEK

UNEMPLOYMENT:	$_____
DISABILITY BENEFITS:	$_____
SSI BENEFITS:	$_____
SOCIAL SECURITY:	$_____
CHILD SUPPORT (PAID TO YOU):	$_____
SELF EMPLOYMENT INCOME:	$_____
VA BENEFITS:	$_____
OTHER INCOME / ASSISTANCE (PLEASE LIST):	$_____
SCHOOL LOANS	$_____
	$_____

I/We understand that by offering detailed financial information to Lake Butler Hospital for the purpose of financial assessment, this in no way discharges the debtor(s) from any expense related to the hospital stay / treatment. I/We understand and agree that an investigative consumer report may be made of the undersigned at any time and references contacted general reputation, personal characteristics, mode of living and eligibility for financial assistance by only Lake Butler Hospital. I/We acknowledge that according to State Statute 817.50 providing false information to defraud a hospital for the purpose of obtaining goods and services is a misdemeanor in the second degree, punishable as provided in s.775.082 or s.755.083. Therefore, I certify that the above information is true and correct to the best of my knowledge.

_____ _____

Responsible Party Date

_____ _____

Registration Clerk Date