

CENTRAL FINANCIAL ASSISTANCE UNIT – NBHD

Patient Number _____

**APPLICATION FOR FINANCIAL ASSISTANCE
AND
INCOME STATEMENT**

I hereby apply for financial assistance for services rendered by a North Broward Hospital District (NBHD) facility.

I certify the following: (check all that apply)

- 1. Family unit income received for the 12 months prior to service date, did not exceed \$«gross_inc».
Can the above income amount be verified? Please check one: YES NO

- 2. The family unit is not currently receiving any regular monthly income, nor have we received such income in the 12 months prior to the date of service, from Social Security, Medicaid, a pension, Unemployment Compensation or any other source.

I/We hereby apply for financial support for services rendered by a North Broward Hospital District (NBHD) facility and certify that the information provided by me and contained hereon is true, accurate, and correct to the best of my knowledge. **I hereby authorize the NBHD and its assignees to order a consumer credit report and verify other credit information. I/We hereby give consent to the NBHD to verify all statements made on this application. I/We authorize Broward Health to release my/our medical and financial information to business associates of Broward Health for audit purposes**

In the event the undersigned, the patient, or any other person on the patient’s behalf are entitled to receive insurance benefits or settlement proceeds because of services rendered to the patient by any facility of the NBHD, said insurance benefits or settlement proceeds are hereby assigned to the NBHD for application against said patient’s hospital bill. Insurance benefits and settlement proceeds will take precedence over the adjusted financial assistance amount. It is further agreed that the NBHD or any of its facilities may issue a receipt to said insurance company for any such payment thereby releasing said insurance company from any and all obligations under the insurance policy to the extent of the payment. The undersigned and the patient, however, remain responsible for the hospital charges not covered by this assignment in the event this application for indigent care is denied.

I/We further understand any changes in income, family size, insurance status or address must be disclosed to the NBHD. The NBHD reserves the right to reevaluate this application for indigent care should additional information become available including but not exclusive to changes in income, family size or address. I/We know that anyone who makes or causes to be made false statement commits a crime punishable by law, and can be fined or put in jail for fraud and/or perjury (Florida Statutes 837.012, 775.082, 817.50). I/We further agree to apply for available local, state, or federally funded health insurance programs for which I/we may qualify and understand that failure to do so will result in denial of the application.

PATIENTS NAME: _____

DATE: _____

PATIENT SIGNATURE : _____

SPOUSE SIGNATURE: _____

GUARANTOR NAME: _____
(If other than patient) (Please Print)

(Relationship to Patient)

WITNESSED BY: _____
(NBHD Representative)

(Second Witness)