

Indebtedness And Living Expenses

Type of Expenses	Monthly Payment	Balance Owed
Mortgage or Rent	_____	_____
Water	_____	_____
Electric	_____	_____
Phone	_____	_____
Cable	_____	_____
Car Payment	_____	_____
Car Insurance	_____	_____
Credit Cards	_____	_____
Personal Loans	_____	_____
Hospital & Doctor	_____	_____
Miscellaneous	_____	_____
Food	_____	_____
SUB TOTAL	<div style="border: 1px solid black; width: 150px; height: 20px;"></div>	<div style="border: 1px solid black; width: 150px; height: 20px;"></div>
Food Stamps	_____	
Public Housing Assistance	_____	
NET INCOME	_____	

- I certify that I am a resident of the Indian River County Hospital District for 6 months or more and that the information given in this application is true and correct. If it is discovered that any information is false, the application may be denied.
- I certify that the information given in this application is true and correct. If it is discovered that any information is false, the application may be denied.

I authorize the hospital to verify all information given. I understand that in accordance with s. 817.50 providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor in the second degree. I also understand that any insurance money or liability recovery which may be paid or due me at a later date for these services must be paid to Indian River Medical Center. Failure to forward any third party recovery amount to the Medical Center will result in rescission of the approval for Indigent Care.

Applicant Signature

Date

Witness Signature/Date