Indian River Medical Center

Referred by
Health Dept. Vero
Health Dept. Gifford
Fellsmere Clinic
Dr. _____
Other _____
_____

APPLICATION FOR
Financial Assistance

Patient Name _____

Marital Status: Single Married Widowed Divorced Separated

Guarantor Name _____

Mailing Address _____ City _____, FL/ZIP _____

Street Address _____ City _____, FL/ZIP _____

How Long a Resident of Indian River County _____ Year(s) _____ Month(s)

Home Phone _____ Cell Phone _____

Family/Personal Information

Family Member Name Include Maiden Name	Relationship	Age	D. O. B.	U. S. Citizen?	Social Security #	Medical Insurance?
	Patient					

TOTAL Number of Family Members: ☐

Income & Employment Information

Patient's/Guarantor Occupation | Employer Name & Address | Monthly Income

Spouse Occupation | Employer Name & Address | Monthly Income

Other | Source of Income | Monthly Income

Financial Information

The following are not considered as source of income for eligibility but rather as liquid assets:

Checking Account: _____ (Bank) _____ (Account #) $_____ (Balance)

Savings Account: _____ (Bank) _____ (Account #) $ _____ (Balance)

The following is not to be used as criteria for determination of eligibility.

Real Estate located at: _____ Mortgage Holder _____
Estimated Value _____ Balance Owed _____ Equity _____

Automobile 1: Year _____ Make _____ Model _____ Balance Due _____
Automobile 2: Year _____ Make _____ Model _____ Balance Due _____

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		

Food Stamps _____

Public Housing Assistance _____

NET INCOME _____

☐ **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 Indian River Medical Center will result in rescission of the approval for financial assistance..

_____ _____

Patient Signature Date

_____

Witness Signature/Date

FINANCIAL INFORMATION RELEASE

Autorización Para Informe Económico

Date (Fecha): _____

To Whom It May Concern:
(A Quien Corresponda)

I hereby grant permission and authorize any bank, building association, employer, insurance company, real estate company, government agency or any financial institution of any kind or character to disclose to any accredited agent of the Indian River Medical Center, full information as to my bank accounts, earnings, insurance policies, property or benefits, for the time period listed below.

(Por la presente autorizo a cualquer banco, compañía de construcción, compañía de seguros, compañía de bienes raices, agencia de gobierno o institución financiera que así lo solicite, suministrar información sobre mis cuentas bancarias, ingresos, polizas de seguro, propiedades o beneficios, por el periodo de tiempo indicado a continuación, a cualquier empleado acreditado en el Indian River Medical Center).

This release is valid from _____ to _____.

(Esta autorización es válida desde _____ hasta _____.)

Signature (Firma) _____

Name on Account_____
(Nombre en la Cuenta)

Information to apply for
Financial Assistance Program at
Indian River Medical Center

All patients need to provide the following documentation at the time of the appointment:

***1 Current Proof of Residency dated within 60 days of signing application**
***Photo ID or <u>two forms of verified identification</u>**
***Verification of household income for the last 8 weeks**

Proof of residency could be:

- Utility bill*
- Telephone bill*
- Rent Receipt*
- Tax bill
- Homestead Exemption
- Drivers License
- Postmarked Junk Mail
- Other acceptable documents to the Tax District

P.O. BOXES CANNOT BE USED AS PROOF OF RESIDENCY

Verification of household income for working applicant must be:

1. Last 8 weeks check stubs from employer or statements from employer indicating gross income
2. Copy of Income Tax Form 1040 (Self-employment only)

Unemployment applicants:

1. Applicant's statement explaining management w/o income
2. Letter of Support provided with photo ID completed by person supporting you

Unemployment Compensation recipients:

1. Paystub or statement from Unemployment Office

Disabled applicants:

1. Disability Office notice of approval (indicating you are disabled)
2. Social Security award letter, TPQY or copy of check

Social Security recipients:

1. Social Security Award letter, TPQY, or copy of check.
2. Social Security Office statement with amount received

If you would like to apply for Financial Assistance you can obtain the application at www.IndianRiverMedicalCenter.com, click on: "Patients & Visitors" then "Billing and Financial Services". Please send via fax completed application to: (772) 794-2596 and we will call you to schedule an appointment. If you will like to contact us for an appointment or have questions, please call at the telephone number listed below or email: financialassistance@irmc.cc.

(772) 567-4311 **Ext. 2450 Rose Gustave (English/Creole)**
Ext. 1195 Leila Correa (English/ Spanish)

All patients of Indian River Medical Center could be eligible for the Financial Assistance Program regardless of age, gender, race or migratory status. Eligibility is based on household income and family size. **Patients who have Medicaid or are potentially eligible for Medicaid will not qualify for this program.** The Financial Assistance Program is good only to cover charges from the Indian River Medical Center, this program will not cover medications, physician's fees or services rendered outside of Indian River Medical Center.