



Account Number:	MR Number:
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Patient's Name: _____ Social Security Number: _____
 Street Address: _____ Telephone #: _____
 City: _____ ST: _____ ZIP: _____

Please provide the following information completely and accurately. Information is subject to verification. *In accordance with Florida Statute Section 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second (2nd) degree.*

List all household member names	Date of Birth	Social Security Number	Relationship to Patient	Age	Sex

Income For	Income Type	Gross Mnthly	Employer Name	Job
Totals				

Expense Type	Monthly	Asset Type	Asset Amnt	Liability Type	Liability Amnt
Rent/Mortgage/Housing		Primary Residence		Residence Mortgages	
Electricity+Other Utility+Gas		Rentals Properties ()		Rental Mortgages	
Water+Sewage+Sanitation		Bank		Credit Card Balances	
Telephone+Cellular				Auto Loan Balances	
Food				Medical Bills	
Auto+Insurance+Gas		Other		Other	
Medical Bills					
Other:					
		Auto			
Totals		Totals		Totals	

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through the South Broward Hospital District d/b/a/ Memorial Healthcare System. If I am entitled to any action against or settlement from third party payors, I will take any action necessary or requested by Memorial Healthcare System to obtain such assistance and will assign to Memorial Healthcare System, and upon receipt will pay to Memorial Healthcare System, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Memorial Healthcare System will result in the denial of this application. I also authorize Memorial Healthcare System to check my credit history through the credit bureau, if deemed appropriate.

Signature of Patient (Responsible Party)

Date

Witness

Extension

2310-10040-07-03

Billing Number:

Patient's Name:	
Account Number:	MR Number:

Official Use Only

Supporting Documents Attached: <input type="checkbox"/> Proof of Income <input type="checkbox"/> Proof of Residency <input type="checkbox"/> Letter of Support <input type="checkbox"/> Alien Sponsor Letter	<input type="checkbox"/> Medical eligible, referral made <input type="checkbox"/> Financial Assistance approved (<150%) <input type="checkbox"/> Uninsured Discount Program <input type="checkbox"/> [] 10% U010 <input type="checkbox"/> [] 20% U020 <input type="checkbox"/> [] 30% U030 <input type="checkbox"/> [] 40% U040 <input type="checkbox"/> [] 50% U050 <input type="checkbox"/> Income >300% Level 6	<input type="checkbox"/> APPLICATION DENIED <input type="checkbox"/> Insufficient data <input type="checkbox"/> No proof of residency <input type="checkbox"/> No proof of Income or Declaration of Income <input type="checkbox"/> Income over scale for Financial Assistance <input type="checkbox"/> Failure to follow through with Medicaid application <input type="checkbox"/> Income over scale for UDP, apply Level 6
Comments:		
Account Representative Signature:	Print Name:	
Telephone & extension #:	Date:	
Address:	Department:	
City, State, Zip:	Email:	

2310-10040-07-03

Billing Number: