Lakeland Regional Health®

LAKELAND REGIONAL MEDICAL CENTER, INC.
FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____ Account #: _____

Guarantor Name: _____ MRN: _____

Address: _____ SSN: _____

_____ Phone: _____

| | |
|---|---|
| Date of Application: | Date of Service: |
| Date of Birth: | Driver's License State and Number: |
| Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Unmarried (single or widowed) | |
| Live with Relative? ☐ Yes ☐ No | US Citizen? ☐ Yes ☐ No |
| Have you applied for Medicaid? ☐ Yes ☐ No | |
| If yes, please provide the date you applied: | Outcome? |
| Have you applied for Disability Assistance? ☐ Yes ☐ No | |
| If yes, please provide the date you applied: | Outcome? |
| Do you have any current or recent health insurance coverage? ☐ Yes ☐ No | |
| If yes, please explain: | |
| Do you receive any type of county assistance? ☐ Yes ☐ No | |
| If yes, please explain: | |

Please provide the following information for all of the people in your household which includes: the patient, the patient's spouse, and all of the patient's dependents and other individuals (related or not) who live in the patient's home. If the patient is under the age of eighteen, the family includes the patient, the patient's natural or adoptive parent(s), anyone claiming the patient as a dependent, and the parent'(s) other dependents who live in the patient's home.

List all household income before taxes, which includes income from all sources: gross wages, salaries, interest, dividends, social security benefits, workers' compensation, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, family-owned business interests, royalties, estates, trust funds, child support and alimony.

## 1. Household Income

| | Number in Same Household | Annual Household Income Gross Salary | All Other |
|---|---|---|---|
| Single Individual | | | |
| Spouse | | | |
| Minor Children | | | |
| Other Dependents Allowed For Income Tax Purposes | | | |
| | | | |
| Total Household Income | | | |

**Please provide the following applicable items to process this request:**

____ Copy of Photo ID/Passport
____ Copy of Income Tax or W2s
____ Copy of most recent pay stub
____ Copy of recent bank statement
____ Expenses relating to business ventures
____ Letter from employer
____ Disability/Medical Report
____ Proof of other income: Workers' Comp, Unemployment, etc.
____ Available assets

| |
|---|
| If you reported no income, please explain if someone else is paying your expenses: |
| Please return all requested information within (10) ten days to:<br>PO Box 95448<br>Lakeland, FL 33804 |
| If you have any questions, please contact a Patient Account Representative at 863.687.1196. |

## 2. Employment Information

| | | | |
|---|---|---|---|
| Employer: | Telephone: | | Occupation: |
| Address: | City: | State: | Length of Employment: |
| Spouse's Employer: | Telephone: | | Occupation: |
| Address: | City: | State: | Length of Employment: |

I understand that this application is made for Lakeland Regional Medical Center, Inc. (LRMC) to judge my eligibility to receive services at no charge, or at a reduced cost, under the Uncompensated Care guidelines established by the State of Florida. Further, I will apply for any and all assistance (Medicare, Medicaid, Insurance, etc.) which may be reasonably necessary to obtain such assistance and assign or pay LRMC all amounts recoverable.

I hereby authorize LRMC, and/or any investigative agency authorized by LRMC, to verify the data reported on this application.

I hereby certify that the foregoing information given by me on this application is true and accurate and is not made with the intent to deceive or defraud LRMC. Should any changes occur, as to the information given by me on this application, I agree to promptly notify LRMC.

**I hereby acknowledge that, in accordance with Florida Statute 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services is a felony of the third degree, and I attest to the fact that the information given is accurate.**

_____ _____
Signature of Patient/Guarantor Date/Time

_____
Relationship to Patient

_____ _____
Witness Signature Date/Time