

STATEMENT OF FINANCIAL CONDITION

Last	First	MI	Social Security #	D.O.B
Home Telephone #		Emergency Contact Telephone #		Alternate Contact Telephone #
Address: Street		City	State	Zip Code
Employer: Company Name			Business Phone #	
Employment Address: Street		City	State	Zip Code
Spouse Employer: Company Name			Business Phone #	
Spouse Employment Address: Street		City	State	Zip Code

Income Information: Last 12 Months Gross Income

	Patient	Spouse	
Family Size:			Was your Medical condition a result of an accident or injury?
Patient's Gross Income:	\$	\$	Yes or No _____
Other Family Income:	\$	\$	
Interest and Dividends:	\$	\$	
Real Estate or Personal Property:	\$	\$	Have you retained the services of an attorney? Yes or No _____
Social Security:	\$	\$	
State Financial Assistance:	\$	\$	
Other Income: (please specify)	\$	\$	Attorney Name: _____
Alimony or Child support payments made: (subtract)	\$	\$	
Current Monthly income	\$	\$	Attorney's Tel#: _____
Total Combined Income:	\$	\$	

Monthly Allowable Expense Information Payment

<input type="checkbox"/> Rent <input type="checkbox"/> Own	Mthly	\$
Utilities	Mthly	\$
Food Allowance	Mthly	\$
Other Allowable Expenses	Mthly	\$
Total Monthly Expenses		\$

Other Considerations

Child Care / Babysitter	Yes	No
Single Parent caring for elders	Yes	No
Cost to provide services exceeds third party reimbursement	Yes	No
Emergency Services?	Yes	No
If patient is deceased is there an estate?	Yes	No

By signing this form I agree to allow Holy Cross Hospital and/or Holy Cross medical group to check employment and credit history for the purpose of determining my eligibility for financial assistance or a financial discount. I understand that I may be required to provide proof of the information listed on the application. I certify that the above information is true and accurate to the best of my knowledge. Further, I understand that I am to apply for any assistance via State county or federal funding, which may be available for payment of my hospital visit, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this charity application applies only to the dates of service and corresponding account numbers referenced on this application for Holy Cross Hospital and Holy Cross Medical Group and that I may incur additional charges from other professional entities of which I will be responsible including but not limited to Anesthesiologists, Radiologists and Pathologists. Unless patient requires a course of treatment based on one diagnosis a new charity form must be submitted for every date of service. I understand that this charity application applies to only Holy Cross Hospital and Holy Cross Medical Group accounts and I may incur additional charges from other professional entities of which I will be responsible including but not limited to Anesthesiologists, Radiologists and Pathologists.

Date of Request: _____

Applicant's Signature: _____

Reviewed by _____
Rev 3/27/2006

Date
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EXHIBIT (A-1)



4725 North Federal Highway
Ft. Lauderdale, FL 33308
(954)-771-8000 – Main Hospital Campus
(954)-267-7771 – Financial Counseling
(954)-596-8001 – Business Office Customer Service

FUNDING ASSISTANCE/INCOME INDIGENCY ATTESTATION STATEMENT

Patient Name: _____

HCH Account Number: _____

I, _____ certify, under the penalty of law that my family income for the past twelve (12) months has been \$_____, and that there are _____ people in my household/immediate family. I certify that I reside in _____ County/Country.

This income information can be verified by calling the following employer(s):

Company Name Phone Number
*If not currently employed please indicate such on the above line by writing “not employed”.

Additionally, I understand that in accordance with S.817.50, providing false information to defraud a hospital for the purposes of obtaining goods for services is a misdemeanor in the second degree.

*By signing this form I agree to allow Holy Cross Hospital to check employment and credit history for the purpose of determining my eligibility for financial assistance or a financial discount.

Guarantor Name Date Guarantor Signature Date

Witness Date Relationship to Patient

State of Florida
County of Broward

The foregoing instrument was acknowledged before me this _____
by _____, who is personally known to me or who has proved
_____ as identification and who did/did not take an oath.

Notary Public Date

EXHIBIT B

Authorization for Funding Assistance

CEO, CFO and/or Vice President of Mission Effectiveness: Above \$15,000

Business Services Director and/or Controller: Up to \$15000

Supervisors: Business Services, Patient Accounting, Admitting and/or Collections and Financial Counselors: Up to \$1,000

Approval Signature

Date

Approval Signature

Date

Approval Signature

Date

Approval Signature

Date

EXHIBIT D

ELIGIBILITY GUIDE: Using household income and size as in Attachment A, identify eligibility for Funding Assistance

Indigent/Charity Guidelines for 2008

Family Size	Period	Federal Poverty Guideline (FPG)	If income is below 200% (shown below) of FPG, eligible for <i>Full Write off</i>	If income is above 200% but below 400% (shown below), eligible for <i>Partial Write off</i>
1	Annual	\$10,400	\$0-\$20,800	\$41,600
2	Annual	\$14,000	\$0-\$28,000	\$56,000
3	Annual	\$17,600	\$0-\$35,200	\$70,400
4	Annual	\$21,200	\$0-\$42,400	\$84,800
5	Annual	\$24,800	\$0-\$49,600	\$99,200
6	Annual	\$28,400	\$0-\$56,800	\$113,600
7	Annual	\$32,000	\$0-\$64,000	\$128,000
8	Annual	\$35,600	\$0-\$71,200	\$142,400
Each additional person		\$3,600	\$3,480	\$3,480

FSG.FT.COLL.606 Federal Charity Guidelines 2008

Catastrophic Coverage:

If Patient Liability is greater than or equal to 25% of the annual family income, amounts greater than 25% of the income may be written off to Funding Assistance due to Catastrophic Circumstances.