

SCS

HCRA



State of Florida, Agency for Health Care Administration

HEALTH CARE ASSISTANCE APPLICATION

In-County \_\_\_\_\_

Applicant's County \_\_\_\_\_

Out-of-County \_\_\_\_\_

of Residence \_\_\_\_\_

PART 1 - HOUSEHOLD INFORMATION - To Be Completed By Applicant

Name: First, Middle, Last	Social Security Number	Date of Birth	Relationship to Applicant	Health Insurance or 3rd Party Coverage								Agency Referred To
				Blind		Disabled		Pregnant				
			<b>PATIENT</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
				Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
				Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
				Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
				Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
				Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
				Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Living Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Shelter Situation:  Rent  Buy  Own  Other \_\_\_\_\_ U.S. Citizen?  Yes  No \_\_\_\_\_

Previously Hospitalized in Florida in Last Year?  YES  NO \_\_\_\_\_ If yes, Where: \_\_\_\_\_ Alien Registration No.: \_\_\_\_\_

PART 2 - FINANCIAL INFORMATION - To Be Completed By Applicant

INCOME					ASSETS			
EXAMPLES	TYPE	WHO HAS	GROSS AMOUNT	HOW OFTEN	EXAMPLES	TYPE	WHO HAS	VALUE
Wages, Self-Employment, Social Security, Child Support Contributions, Unemployment Compensation, Railroad Retirement, SSI, AFDC			\$		Cash, Checking account, Car/truck, Motorcycle, Burial insurance, Trust funds, Life insurance, Burial plot, Real estate, Business equipment, Boat, Stocks/Bonds, Savings			\$
			\$					\$
			\$					\$
			\$					\$
			\$					\$
		TOTAL INCOME	\$			TOTAL ASSETS	\$	

PART 3 - DECLARATION

I am applying for assistance. I understand that I will have to give true information on this form. It could be a crime if I am not truthful about my eligibility for assistance.

I agree to turn in papers that are required to show that I am eligible, except for papers I cannot get through no fault of my own. If I cannot get papers, I agree to give the names of persons or places that may be contacted for the required information.

I agree to apply for any other medical assistance program I may be eligible for.

I agree that the Agency for Health Care Administration or the county may verify the information I give on this form and at my interview. I agree that they may contact my present or past employers, if it relates to my eligibility. I agree that they can get information that affects my eligibility from any records.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Spouse's or Representative's Signature \_\_\_\_\_

Date \_\_\_\_\_

PART 4 - PATIENT INFORMATION - To Be Completed by Hospital Personne

Date Admitted or Services Provided: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_ Patient Account No.: \_\_\_\_\_ Deceased: Yes  No  Date: \_\_\_\_\_

Case Mgmt. Agency: \_\_\_\_\_  Enrolled  Referred Date: \_\_\_\_\_ Previously Hospitalized in this hospital in Last Year?  YES  NO \_\_\_\_\_ If yes, When: \_\_\_\_\_ InPatient: \$ \_\_\_\_\_ # Days Total Charge \_\_\_\_\_

PART 5 - REFERRAL HOSPITAL - To Be Completed By Hospital Personne

Referral Hospital: \_\_\_\_\_ Hospital HCRA ID #: \_\_\_\_\_

Address: \_\_\_\_\_ Date Sent To County: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Charity Obligation Met? Yes  No

PART 6 - COUNTY/AGENCY USE

WORKER: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Application Approved: Yes  No

**DATE STAMP**

When entering a date - Please use the MM/DD/YYYY format, example:  
06/15/1961.  
When entering dollar amounts - do not use a comma.

Use the tab key to navigate the form.

### **INSTRUCTIONS TO PATIENT/APPLICANT**

- We would like you to fill out as much of Part 1 and Part 2 on the front as you can. If you cannot fill it out, a hospital worker will help you.
- In Part 1, list your name first and then list the names of all relatives that live with you.
- DO NOT write in Parts 4, 5, and 6. These are for office use only. DO NOT write on the back of this form.
- In order for this form to count as an application for assistance in paying your hospital bill, you must read, sign and date Part 3 on the front. Be sure to fill in your address so we can contact you about an interview should we need to request additional information.
- Return ALL COPIES of this form to a hospital staff person.

### **INSTRUCTIONS TO HOSPITAL WORKER**

- Complete Part 1 and Part 2 for the patient/applicant unless the patient/applicant wants to do it.
- Assist the patient/applicant in obtaining all necessary verifications.
- Give the YELLOW copy of the form to the patient/applicant.
- Complete Part 4 and Part 5. Sign Part 3 if the patient is unable to sign or if the hospital is acting as the patient's representative.
- Send the WHITE copy to the certifying agency for processing with all verification obtained.
- Retain the PINK copy for your records.

### **INSTRUCTIONS TO CERTIFYING AGENCY**

- Date stamp in Part 6 upon receipt.
- Determine whether all necessary verification has been provided.
- Schedule an interview with the patient/applicant to obtain additional information if necessary.
- Determine eligibility.
- Notify patient/applicant and referring hospital of decision.