Leesburg Regional Medical Center
The Villages Regional Hospital
714 Pine St. Leesburg, FL 34748

DOS Financial Assistance Application
Account #
Email **Food Stamp Y/N**

CONFIDENTIAL FINANCIAL STATEMENT

Please print and use blue or black ink only

Patient Name_____ Patient Social Security Number_____
Guarantor Name_____Guarantor Social Security Number_____
Legal Residence (do not use P.O. Box)_____
County of Residence_____How Long_____
Mailing Address if different (list P.O. Box here)_____
Phone No_____Date of Birth_____US Citizen___Yes__No
Lawful Non-Citizen___Yes___No Alien Registration Number_____

LIST OF ALL LEGAL MEMBERS/DEPENDENTS OF HOUSEHOLD:

Name	Relationship to Applicant	Date of Birth	Social Security Number

LIST OF ALL EMPLOYERS FOR THE LAST 12 MONTHS (starting with current; if there are more than two, attach additional sheet):

Employer_____From_____To_____
Address_____
Gross Monthly Income_____Full-Time____Part-Time____ Insurance Coverage___Yes___No
If yes, Name of Insurance_____Contact phone number to verify insurance_____
2nd Employer_____From_____To_____
Address_____
Gross Monthly Income_____Full-Time____Part-Time____ Insurance Coverage___Yes___No
If yes, Name of Insurance_____Contact phone number to verify insurance_____

LIST ALL INCOME FOR HOUSEHOLD (example: gross wages, self-employment income, child support, alimony, rental income, trusts, investments, Social Security benefits, SSI, W2,veterans benefits, pensions, annuities, unemployment, Workers' Compensation):

Name	Income Type	Income Amount	Frequency of Income

LIST ALL ASSETS (example: checking, savings, stocks, bonds compensation, certificate of deposit, IRA, 401K, insurance policies with cash value, 2nd property, 2nd car, 2nd truck, RV, motorcycle, ATV, boat, etc.):

Name	Asset Type	Asset Fair Market Value

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MONTHLY EXPENSES

Type	Original Balance	Monthly Payment	Present Balance	Is There Any Additional Information We May Need in Order to Process Your Application?
Mortgage				
Rent/Lease				
Room & Board				
Land/Lot				
Electric				
Food				Food Stamp Amount:
Water				
Cable				
Telephone				
Cellular Phone				
Total Amount of Auto payment(s)				
Gas (Propane)				
Gas Expense				
Auto Insurance				
Total Amount of Credit Card(s)				
Total Amount of Loan(s)				
Medical Expense				
Life Insurance				
Child Care / Support				
Other				

Have you applied for Medicaid?_____ Total Net Income $_____
Have you applied for SSD?_____ Date:_____ Monthly Expenses - $_____
If yes, nature of disability_____ Remaining After Expenses $_____

The statements and information provided on the front and back of this financial statement is submitted by the undersigned for the purpose of receiving financial assistance or establishing an alternative payment plan for disposing of consumer debt owed to LRMC/TVRH. I/We authorize LRMC/TVRH to make the credit inquiries and obtain my/our credit record history from credit reporting agencies in order to verify the statements and to answer any questions LRMC/TVRH may have concerning my/our credit record.

I swear that the above information is true and correct.

_____
Applicant's Signature

_____
Witness Signature

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INCOME CERTIFICATION

I, _____, certify that my family income for the past 12 months was $_____ per year, or $_____ per month, or $_____ per week and there are _____ legal dependents in my family. If you have zero (0) income for the past 12 months, you must provide a Letter of Hardship with an explanation of how you are paying your bills (food, transportation, etc.). I/We authorize Leesburg Regional Medical Center and/or The Villages Health System to verify the income information by contacting the following employer(s):

_____ _____
(Patient) Employer/Company Employer Phone

_____ _____
(Spouse) Employer/Company Employer Phone

SPECIAL NOTE: If you are "self-employed", a copy of your most current, filed Federal Income Tax Return is required for eligibility determination for special financial assistance programs. Additionally, your request for financial assistance program consideration authorizes Leesburg Regional Medical Center and/or The Villages Health System to access your credit information from all credit reporting agencies for you, your spouse and your business.

I understand that in accordance with Florida Statute 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services is crime, a misdemeanor in the second degree.

_____ _____
Patient/Guarantor/Responsible Party Signature Date

_____ _____
Witness Signature Date

_____
Witness Printed Name