PART IV – Uninsured Screening Questionnaire

THIS IS A SCREENING QUESTIONNAIRE UTILIZED IN HELPING TO DETERMINE POSSIBLE MEDICAL FINANCIAL ASSISTANCE. PLEASE ANSWER ALL QUESTIONS.

(circle one)

Yes / No 1. Are you under 18 years of age?

Yes / No 2. Do you have children under 18 years of age and are they living with you?

Yes / No 3. Are you pregnant or a new mother?

Yes / No 4. Are you under 21 years of age and living with a family member?

Yes / No 5. Are you 65 years of age or older, blind or totally disabled?

Yes / No 6. Do you spend a large part of your income on medical care?

Yes / No 7. Have you ever applied for Medicaid?

Yes / No 8. Do you have a current application for Medicaid?

Yes / No 9. Do you have proof of Medicaid denial?

Yes / No 10. Have you ever applied for Social Security?

Yes / No 11. Have you ever been denied Social Security?

Yes / No 12. Are you appealing your denial?

Yes / No 13. Are you an illegal alien who needs emergency service?

Yes / No 14. Are you a named party in any lawsuits or litigation?

If yes, please explain:

_____

_____

_____

_____

PART IV—AUTHORIZATION

I certify that the above information is both complete and correct to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, insurance, etc.) which may be available for payment of my Northwest Florida Community Hospital bill. I will also take any action reasonable necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that Northwest Florida Community Hospital can judge my eligibility for uncompensated services, based on the established criteria on file. I understand that the information given is subject to verification by the hospital. If any information I have given proves to be untrue, I understand the hospital may reevaluate my financial status and take whatever action becomes appropriate. Additionally, I understand that in accordance with Florida Statue 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree.

I understand my signature authorizes the Department of Children and Families to release information regarding the disposition of my application for Medicaid or public assistance.

Patient:_____ Date:_____

Guarantor/Spouse/Parent:

_____ Date:_____

Hospital Representative:

_____ Date:_____

For NFCH to consider your account for possible financial assistance:

1. Complete all questions in the Financial Assistance Application
2. Include a recent pay stub, income tax return or income verification.
3. Include a photo ID (driver's license or personal photo ID)
4. Mail or deliver to NFCH within ten (10) working days

If you have no income:

1. Include a statement from a family member or friend verifying that you cannot pay your hospital bill and financial assistance is needed
2. Include a telephone number where this person can be reached.

We urge you to mail or deliver all requested information to NFCH **within ten (10) working days** (copies are accepted). If any item is omitted, your application will be considered incomplete. This will delay the review of your account.

PLEASE NOTE: To be considered for financial assistance, you cannot be eligible for Medicaid ***or*** receive any other monetary support.

Feel free to call our Financial Counselor at 850-415-8165 if you have questions regarding our financial assistance process. We will be glad to answer any questions you may have.

FINANCIAL ASSISTANCE APPLICATION

Provided by:

NFCH
Northwest Florida Community Hospital

1360 Brickyard Road - P. O. Box 889
Chipley, FL 32428 - 850-638-1610
Fax: 850-638-0622

Email: financial-counselor@nfch.org
Website: www.nfch.org

Application for Financial Assistance

PART I – Patient Information

Patient Name:______________________________

Last First Middle

____

Social Security # Date of Birth Telephone #

Address:______________________________

Street/Apt # City State/Zip

Employer:______________________________

Name of Employer

____

Address Telephone #

PART II – Family Information

Name	**Age**	**Relationship**

(Complete only if different from Patient)

Guarantor / Responsible Party:

____

Last First Middle

____

Social Security # Telephone #

Address:______________________________

Street/Apt # City State/Zip

Employer:______________________________

Name of Employer

____

Address Telephone #

PLEASE RETURN WITHIN TEN (10) WORKING DAYS

PART III – Financial Infor–

	Patient
HOUSEHOLD INCOME	
Annual Wages	
ASSET INFORMATION	
Checking Account	
Savings Account	
Money Market	
CDs	
IRA's	
Other	

	Persons Listed in Part II
HOUSEHOLD INCOME	
Annual Wages	
ASSET INFORMATION	
Checking Account	
Savings Account	
Money Market	
CDs	
IRA's	
Other	

	Persons Listed in Part II
HOUSEHOLD INCOME	
Annual Wages	
ASSET INFORMATION	
Checking Account	
Savings Account	
Money Market	
CDs	
IRA's	
Other	

	Persons Listed in Part II
HOUSEHOLD INCOME	
Annual Wages	
ASSET INFORMATION	
Checking Account	
Savings Account	
Money Market	
CDs	
IRA's	
Other	