



### Financial Assistance Application

Today's Date:	Intake Representative:
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<b>PATIENT INFORMATION</b>
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Patient Name	Account Number	Date of Birth	Legal Status
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Address:

Social Security no.:	Home phone no.:	Cell phone no.:
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Occupation:	Employer:	Employer phone no.:
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Spouse/Responsible Party Name	Relationship to Patient	Social Security Number	Date of Birth	Phone Number
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Occupation:	Employer:	Employer Phone Number	
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<b>FAMILY UNIT</b>
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Number of People in Family Unit (Including Patient): \_\_\_\_\_

Name	Date of Birth	Social Security Number	School/Grad

<b>PRESUMPTIVE ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE</b>
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Does Presumptive Eligibility Criteria Apply?  YES  NO    If YES, select the criteria that applies to the Presumptive Eligibility Criteria

State Funded Prescription Program	"> <input type="checkbox"/>	Subsidized School Lunch Program	"> <input type="checkbox"/>
Homeless	<input type="checkbox"/>	Eligibility for Other State or Local Unfunded Assistance Program	<input type="checkbox"/>
Participation in WIC Program	<input type="checkbox"/>	Low Income Subsidized Housing Provided as a Valid Address	<input type="checkbox"/>
Food Stamp Eligibility	<input type="checkbox"/>	Patient is Deceased With No Known Estate	<input type="checkbox"/>
Medicaid Eligibility With Exhausted Benefits or Coverage Limits Exceeded	<input type="checkbox"/>		

**MONTHLY INCOME**

Income	Patient	Spouse/Responsible Party	Combined Income
Gross Monthly Wages/Salary			
Gross Yearly Wage/Salary			
Social Security Benefits			
Child Support/Alimony			
Workers Compensation			
Other Income			
<b>Total Income</b>			

**ASSETS**

Assets	Asset Name	Patient	Spouse/Responsible Party	Total Combined Assets
Checking				
Savings				
Stocks/Bonds/Money Markets				
Income from Estates or Trusts				
Secondary Home Value				
Secondary Vehicle Value				
<b>Total Assets</b>				

**HOUSEHOLD EXPENSES**

Expenses	Patient	Spouse/Responsible Party	Total House Expense
Telephone			
Utilities			
Food			
Credit Cards			
Cable Television			
Other			
<b>Total Expense</b>			



To the best of my knowledge the above information is true, and I am aware that any person(s) who knowingly makes a false statement or a misrepresentation in the application shall be subject to all penalties as prescribed by law. By copy of the document, the guarantor is hereby advised that the above information may be verified.

Patient/Guardian Signature	Date
Relationship to Patient	

**Lakeside Medical Center Use Only**

Proof of Palm Beach County Residency Provided	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Total Number in Family Unit		
Total Combine Monthly Income		
Total Combine Assets		
Total Combine Household Expenses		
Does Patient Meet Federal Poverty Guidelines?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Federal Poverty Level Guideline Ratio		
Financial Assistance Approval Date		
Financial Assistance Denial Date		
LMC Financial Counselor Name		
LMC Financial Counselor's Signature		Date:

Eff: 04/01/2017