Financial Assistance Evaluation Form

Client's Name: _____
Street Address: _____ City: _____
ST: _____ ZIP: _____ Telephone Number: _____
Email Address: _____

Please provide the following information completely and accurately. Information is subject to verification. ***In accordance with Florida Statute Section 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second (2nd) degree.***

Dependents in Household	Age	Relationship to Client

Monthly Income		Monthly Expenses	
Client's Gross Salary	$	Rent/Mortgage/Housing	$
Spouse's Gross Salary	$	Electricity	$
Investment Income	$	Water/Sewage	$
Child Support/Alimony	$	Telephone	$
Rental Property Income	$	Groceries	$
Annuities/Stocks/Dividends	$	Transportation	$
Pensions/Retirement/Unemployment	$	Medical Bills	$
Other:	$	Other:	$
Total Value of Assets:	$	**Total Liabilities:**	$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this client other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through Florida Center for Recovery, Inc. If I am entitled to any action against or settlement from third party payors, I will take any action necessary or requested by Florida Center for Recovery Inc. to obtain such assistance and will assign to Florida Center for Recovery Inc., and upon receipt will pay to Florida Center for Recovery Inc., all amounts recovered up to the total amount of the outstanding balance on my bill.

_____ _____
Signature of Client (Responsible Party) Date

_____ _____
Witness Extension