Love The Golden Rule, Inc.
Nonprofit Medical Clinic

Financial Assistance Application

To apply for financial assistance for medical expenses incurred at Love The Golden Rule, please complete the attached application and return it to the clinic. It is very important to follow the instructions below in order for your application to be reviewed:

- List financial information for a full 12 months on the application.
- Applications must be signed AND witnessed on same date to be considered for assistance. Notary is not required.

Application will be reviewed to determine programs that may be able to assist. If additional information is needed, a representative will contact you.

SPECIAL NOTICE TO MEDICARE RECIPIENTS ONLY	POTENTIAL MEDICAID PARTICIPANTS
Federal regulations require Medicare recipients to provide proof of income and assets when applying for financial assistance. **Required proofs:** • **Proof of Income: copy of notices from Social Security, Unemployment Compensation, pensions, rental income or ANY income used to pay your expenses** • **No Income: provide a letter of support from the individual assisting you** • **Proof of Assets: current bank statement, debit card statement, value of IRA , stocks, bonds, 401k's, whole life insurance policy cash value, and real estate (other than homestead)**	• **Are you pregnant OR have a child aged 17 or under in your custody?** • **Are you between the ages of 18-21?** • **Are you over 65 years of age?** • **Are you receiving Social Security disability?** **If you answered yes to any of these questions, you are potentially eligible for Medicaid. Visit www.myflorida.com/accessflorida to complete a Medicaid application.**

Application can be emailed to_____, or faxed to (727) 351-8022

ATTENTION: Sending unencrypted email is not a secure method of sending protected health information (PHI). The information you send, unless encrypted, could be electronically captured during transmission.

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Patient Chart #: _____ **PATIENT Name:** _____ **Date of Birth**_____

Address: _____

City, State, ZIP_____ **City, State, ZIP** _____ **Phone:** _____

Email: _____ **Pregnant:** ☐Yes ☐ No **Disabled**: ☐Yes ☐No **Marital Status:** ☐ M ☐ S ☐ D ☐ W ☐ X*
*married, but separated, living apart

HOUSEHOLD INFORMATION Households are defined as spouses, parents of minors, minors and/or siblings under 21 living together

Household Members PLEASE INCLUDE PATIENT INFORMATION	DOB	Relationship to Patient	Tax Filing Status Choose Individual, Joint, Dependent, Not Filing
		Self/Patient	

HOUSEHOLD INCOME List all income/no income for household members listed above including patient.

Name of household member with or without income in the past 12 months, from date of application	Income Source: Employer Name, Self-Employment, Odd Jobs, No Income, Workman's, Unemployment Compensation, pensions, rental income, trust funds, child support, alimony, Social Security, Veteran's Administration	Number of months with income	Number of months without income	Current Gross Monthly Income	Yearly Gross Income List total income for the past 12 months from date of application
Self/Patient					
	Total:				

Have you applied for any program listed below in the past 12 months:
Circle all that apply

Medicaid

Social Security Disability

County Medical Coverage

Workers Compensation

Health Insurance Marketplace

If you are claiming No Income, tell us who is supporting you _____

Is there health/auto insurance to cover any cost of your medical care? ☐Yes _____ ☐ No
Insurance/Policy#

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Love The Golden Rule LLC reserves the right to review and adjust any prior financial decision, including the reversal of write-offs, if information provided is later found to be inaccurate, incomplete, or if medical bills relate to an accident with subsequent recovery of funds.
I certify that the information provided is true and accurate. I understand that, in accordance with Florida Statute §817.50, providing false information to obtain medical goods or services is a misdemeanor of the second degree.

I authorize Love The Golden Rule to verify the information provided, including obtaining a consumer credit report for the limited purpose of financial assistance or payment verification.

_____ _____ _____ _____
Patient/Guarantor Signature **Date** **Witness Signature (no notary required)** **Date**

PATIENT AND WITNESS SIGNATURE MUST BE SAME DATE TO BE CONSIDERED A VALID APPLICATION