224 NW Crane Ave Madison, FL 32340
Phone: (850) 973-2271
Fax: (850) 973-2818
Federal Employer Identification No. 59-2319288

Madison County Memorial Hospital

Request for Financial Assistance

Dear Patient and Family:

In keeping with its mission and core values, Madison County Memorial Hospital is committed to providing health care for people regardless of their ability to pay.

MCMH Financial Assistance Medical bills may be difficult to pay. Patients who do not have health insurance or who are unable to pay for all of part of their health care services, may apply for financial assistance by completing and returning this form.

Options Available MCMH will work with patients to see if they qualify for interest free payment plan options or financial assistance.

Application Process To apply for financial assistance, you must make an appointment. To make an appointment, please call

MCMH Financial Counselor
(850) 253-1955

The following information must be included with the application:

1. Photo ID showing your current address. If your address has change, bring a piece of mail with your name and current address on it.
2. Copy of Social Security Cards from everyone in your household.
3. Proof of all income (2) current paychecks stubs, Child Support, SSI, Social Security Benefits, etc.

Without the above listed items, MCMH will be unable to process the application.

Questions? Please call our Financial Counselor at 850-253-1955

This completed application, including the supporting information, should be returned with 10 days of receipt.

By submitting application for assistance, patients give MCMH consent to make necessary inquiries to confirm financial obligations or reference.

Sincerely,
Madison County Memorial Hospital

Financial Assistance Application

Madison County Memorial Hospital

224 NW Crane Ave

Madison, Florida 32340

Date of Request: _____ Social Security Number: _____

Name: _____

Last First Middle

Address: _____

Street City State Zip

Telephone Number: _____

Occupation: _____ Employer: _____

Family Size

Name	Date of Birth	Relationship

Income

List income for family from		Past 12 Months
Wages		
Farm of Self-Employment (Net Income)		
Public Assistance		
Social Security		
Unemployment Compensation		
Strikes Benefits		
Alimony		
Child Support		
Military Family Allotments		
Pensions		
Income from Dividends/Interest/Rent		

Total number of people in family: _____

Total Family Income for the Past 12 Months: _____

Monthly Expenses

House Payments _____ or Rent _____
Automobile Payment _____ Auto Insurance _____
Lights _____ Water/Sewage/Garbage _____
Propane/Natural _____

Assets

Name of Bank _____
Savings Amount _____
Checking Amount _____
Property Owned and Value of _____
Value of Home _____
Value of Car _____ Year & Model of Car _____

As provided for in Federal or State Law, I hereby request that Madison County Memorial Hospital make a written determination of my eligibility for uncompensated service. I understand that the information which I submit concerning my annual income and family size is subject to verification by Madison County Memorial Hospital. I also understand that if the information I submit is determined to be false, such a determination will result in denial, and that I will be liable for charges for service provided. Initial _____

Additionally, I understand that in accordance with Florida Statutes 817.50, providing false information to defraud a hospital or the purpose of obtaining good or services is a misdemeanor in the second degree. Initial _____

Also, I acknowledge that I must inform the Financial Counselor of any ER visits while on this program. Initial _____

_____ _____
Date Signature of Patient of Representative

Madison County Memorial Hospital
Maximum Income Level per family size
to qualify for County Indigent or Charity

Family Size		**Indigent** 100%		**Charity** 125%
1		$12,490		$15,613
2		$16,910		$21,138
3		$21,330		$26,663
4		$25,750		$32,188
5		$30,170		$37,713
6		$34,590		$43,238
7		$39,010		$48,763
8		$43,430		$54,288

For Familes with more than 8 members add $4,420 for each additional member. In addition the applicant may not have more than $5,000 worth of assets. However, pursuant to the section 10c-26.06 Florida Administrative Code, the value of the following assets are not included in the $5,000 limit

A. Homestead B. Household Furnishings C. One Vehicle
D. Clothing E. Tools Used in Employment F. Cemetery Plots. Etc.

Ownership of the above listed items will not prevent an applicant from qualifying a indigent. Food stamps are not to be included in an applicant's income. Family size is to include any relative living under the same roof and any non-related children under 5 years of age and living under the same roof.

Figures are based on the 2019 HHS Poverty Guidelines
Revised : 4/2/2019 MEH

Health Care Responsibility Act
Calculation of Monthly Household Expenses

Name of Head of Household: _____

Address for Household: _____ County: _____

Monthly Expenses	Paid by Whom	Monthly Payment $
Mortgage/Rent		
Electricity		
Water/Sewage		
Phone (Home and Cell)		
Cable/Internet		
Food (Excluding Food Stamp purchases)		
Car Payment		
Car Insurance		
Other Monthly Expenses Not Specified Above		
Total Monthly Expenses		$
Number of Adults in the home (Persons over 21 years of age)		
Applicant's Contribution (Divide Total Expenses by Number of Adults)		$

_____ _____

Name of Payer (Please Print) Signature of Payer

_____ _____

Applicant's Name (Please Print) Signature

_____

Applicant's Address

_____

City State Zip Code County

_____

Date

Note: This form may be used for HCRA applicants who claim zero monthly income.

Madison County Indigent Application

In-County: _____ Out-of-County: _____
Applicant's County of Residence: _____

PART 1 – HOUSEHOLD INFORMATION – To Be Completed By Applicant

Name: First	Middle	Last	Social Security Number	Date of Birth	Relationship to Applicant
					PATIENT

Address:

Previously Hospitalized in the Last Year? ☐ Yes ☐ No If yes, Where?

Phone Number: ( )

Shelter Situation: ☐ Rent ☐ Buy ☐ Own Other

US Citizen? ☐ Yes ☐ No

PART 2 – FINANCIAL INFORMATION – To Be Completed By Applicant

INCOME

EXAMPLES	TYPE	WHO HAS	GROSS AMOUNT	HOW OFTEN
Wages, Self-Employment, Social Security, Child Support Contributions, Unemployment Compensation, Railroad Retirement, SSI, AFDC			$	
			$	
			$	
			$	
			$	
	Total Income		$	

ASSETS

EXAMPLES	TYPE	WHO HAS	VALUE
Cash, Checking Account, Car/Truck, Motorcycle, Burial Insurance, Trust Funds, Life Insurance, Burial Plot, Real Estate, Business Equipment, Boat, Stocks/Bonds, Savings			$
			$
			$
			$
			$
			$

PART 3 – DECLARATION

I am applying for assistance. I understand that, in addition to completing this form, I may have to provide accurate sources of information and verification in regards to eligibility requirements. I understand I may be asked for an interview and am expected to keep appointments. I agree to apply for any other medical assistance program I may be eligible for. I authorize release of such eligibility determination information to the certifying agency as deemed necessary in connection with my application. I understand that I may have a share of cost that I will be responsible to pay to the hospital. It could be a crime if I am not truthful about my eligibility for assistance. Sound it be determined that fraud was committed, or incorrect information was intentionally provided, resulting in an inappropriate eligibility determination, I will be responsible for repaying any amounts paid on my behalf.

_____ Signature _____ Date

_____ Spouse's or Representative's Signature _____ Date

PART 4 – REFERAL HOSPITAL – To Be Completed By Hospital Personnel

Referral Hospital Madison County Memorial Hospital

Address 224 NW Crane Ave Madison, FL 32340

Hospital HCRA ID # _____

Date Sent to County: _____

Signature _____

Print Name _____ Phone Number: (850) 253-1955

Charity Obligation Met? ☐ Yes ☐ No

☐ HCRA ☐

State of Florida, Agency for Health Care Administration

HEALTH CARE ASSISTANCE APPLICATION

In-County _____
Out-of-County _____

Applicant's County of Residence ____________

PART 1 - HOUSEHOLD INFORMATION - To Be Completed By Applicant

Name: First, Middle, Last	Date of Birth	Relationship to Applicant	Health Insurance or 3rd Party Coverage		Blind		Disabled		Pregnant		Agency Referred To
		PATIENT	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	
			Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	
			Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	
			Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	
			Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	
			Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	
			Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	

Living Address: ____________ Mailing Address: ____________

Previously Hospitalized in Florida in Last Year? ☐ Yes ☐ No If yes, Where:

Phone Number: ( ) Shelter Situation: ☐ Rent ☐ Buy ☐ Own ☐ Other U.S. Citizen? ☐ Yes ☐ No Alien Regisgration No.:

PART 2- FINANCIAL INFORMATION - To Be Completed By Applicant

INCOME

EXAMPLES	TYPE	WHO HAS	GROSS AMOUNT	HOW OFTEN
Wages, Self-Employment, Social Security, Child Support Contributions, Unemployment Compensation, Railroad Retirement, SSI, AFDC			$	
			$	
			$	
			$	
			$	
		TOTAL INCOME	$	

ASSETS

EXAMPLES	TYPE	WHO HAS	VALUE
Cash, Checking account, Car/truck,			$
Motorcycle, Burial insurance, Trust			$
funds, Life insurance, Burial plot,			$
Real estate, Business equipment,			$
Boat, Stocks/Bonds, Savings			$
		TOTAL ASSETS	$

PART 3 - DECLARATION

I am applying for assistance. I understand that, in addition to completing this form, I may have to provide accurate sources of information and verification in regards to eligibility requirements. I understand I may be asked for an interview and am expected to keep appointments. I agree to apply for any other medical assistance program I may be eligible for. I authorize release of such eligibility determination information to the certifying agency as deemed necessary in connection with my application. I understand that I may have a share of cost that I will be responsible to pay to the hospital. It could be a crime if I am not truthful about my eligibility for assistance. Should it be determined that fraud was committed or incorrect information was intentionally provided, resulting in an inappropriate eligibility determination, I will be responsible for repaying any amounts paid on my behalf.

Signature ____________ Date ____________ Spouse's or Representative's Signature ____________ Date ____________

PART 4- PATIENT INFORMATION - To Be Completed by Hospital Personnel

Date Admitted or Services Provided: ______ Date of Discharge: ______ Patient Account No.: ______

Case Mgmt. Agency: ______ ☐ Enrolled ☐ Referred Date: ______

Deceased: Yes ☐ No ☐ Date: ______

Previously Hospitalized in this hospital in Last Year? Yes ☐ No If yes, When: ______

InPatient: ______ # Days
OutPatient $ ______ Total Charge

PART 5 - REFERRAL HOSPITAL - To Be Completed By Hospital Personnel

Referral Hospital: ____________ Hospital HCRA ID #: ______

Address: ____________ Date Sent To County: ______

Signature: ____________

Print Name: ____________ Phone Number: ( ) ______

Charity Obligation Met? Yes ☐ No ☐

PART 6 - COUNTY/AGENCY USE

WORKER:

Name

Phone Number

Application Approved: Yes ☐ No ☐

DATE STAMP

INSTRUCTIONS TO PATIENT/APPLICANT

- We would like you to fill out as much of Part 1 and Part 2on the front as you can. If you cannot fill it out, a hospital worker will help you.
- In Part 1, list your name first and then list the names of all relatives that live with you.
- DO NOT write in Parts 4, 5, and 6. These are for office use only. DO NOT write on the back of this form.
- In order for this form to count as an application for assistance in paying your hospital bill, you must read, sign and date Part 3 on the front. Be sure to fill in your address so we can contact you about an interview should we need to request additional information.
- Return ALL COPIES of this form to a hospital staff person.

INSTRUCTIONS TO HOSPITAL WORKER

- Complete Part 1 and Part 2 for the patient/applicant unless the patient/applicant wants to do it.
- Assist the patient/applicant in obtaining all necessary vertifications.
- Give the YELLOW copy of the form to the patient/applicant.
- Complete Part 4 and Part 5. Sign Part 3 if the patient is unable to sign or if the hospital is acting as the patient's representative.
- Send the WHITE copy to the certifying agency for processing with all verification obtained.
- Retain the PINK copy for your records.

INSTRUCTIONS TO CERTIFYING AGENCY

- Date stamp in Part 6 upon receipt.
- Determine whether all necessary verification has been provided.
- Schedule an interview with the patient/applicant to obtain additional information if necessary.
- Determine eligibility.
- Notify patient/applicant and referring hospital of decision.