Lakeside Medical Center
Health Care District Palm Beach County

Financial Assistance Application

Today's Date:	Intake Representative:

PATIENT INFORMATION

Patient Name	Account Number	Date of Birth	Legal Status

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Spouse/Responsible Party Name	Relationship to Patient	Social Security Number	Date of Birth	Phone Number
Occupation:	Employer:	Employer Phone Number		

FAMILY UNIT

Number of People in Family Unit (Including Patient): _____

Name	Date of Birth	Social Security Number	School/Grad

PRESEUMPTIVE ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE

Does Presumptive Eligibility Criteria Apply? ☐YES ☐NO If YES, select the criteria that applies to the Presumptive Eligibility Criteria

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

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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			
Total Income			

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				
Total Assets				

HOUSEHOLD EXPENSES			
Expenses	Patient	Spouse/Responsible Party	Total House Expense
Telephone			
Utilities			
Food			
Credit Cards			
Cable Television			
Other			
Total Expense			

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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	☐ YES ☐ NO	
Total Number in Family Unit		
Total Combine Monthly Income		
Total Combine Assets		
Total Combine Household Expenses		
Does Patient Meet Federal Poverty Guidelines?	☐ YES ☐ 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