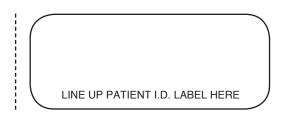


3090 Caruso Ct., Suite 20 Orlando, Fl. 32806 FinancialAssistance@orlandohealth.com
Phone 321.843.8955 Fax: 321.843.1532

Guarantor Financial Statement



In an effort to meet the community's healthcare needs, financial assistance is available to patients/guarantors (person that is financially responsible) who have limited or no resources to pay for emergent or medically necessary services rendered at an Orlando Health facility. This Guarantor Financial Statement is used to evaluate a Patient or Guarantor's eligibility for financial assistance provided by Orlando Health. Completed Guarantor Financial Statements received by the Community Care Assistance Department will be reviewed to determine if you are eligible for financial assistance. This application is for consideration of the hospital and hospital employed physicians' charges only and does not assist with other non-Orlando Health provided services which you may have received related to your care at Orlando Health. It is important this Guarantor Financial Statement be completed in its entirety. This form is valid for financial assistance consideration for care received six months prior to and six months after the signature date on this form.

Upon request, you are responsible for providing timely information about your health benefits, income, assets, and any other paperwork that will help to see if you qualify. Paperwork might be bank statements, income tax forms, check stubs, or other documents

documents.									
Patient Name:									
Patient Relations	hip to Guar	antor:							
			GUARAN	ITOR	INFORMAT	ION			
Guarantor Name:						Date of Birth:			
SSN/TIN:						Self Employed:	Yes	No	
Disabled: Yes	No	Marita	l Status: M S	D_	W	Homeless:	Yes	No_	
Address:									 -
City:				Sta	ate:	Zip):		
Home Phone:				Ce	ell Phone:				
Email Address: _									
Are you a US Citi								All f	ields required
* Financial Assista country resident w 1. In the pas	ith a govern	ment i		ication	Number (TIN)	·	. OI a 1 0 (gany pen	inted out of
Medicaid	Social Sec Disabili		County Medical Assistance		Workers ompensation	Health Exchang Marketplace	ge O	THER	NONE
	DLD/FAMILY der 21 living			holds a	are defined as	spouses, parents	of mino		s and/or fields required
Household Member Relation		ationship to Guarantor		Date of Birth		Tax Filing Status (select Individual, Joint, Not Filing)			

Total # of household members:



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LINE UP PATIENT I.D. LABEL HERE	

Guarantor Financial Statement

3. HOUSEHOLD/FAMIL	Y INCOME Provide income for	yourself, your spouse and all otl	ner family members
(if applicable)			All fields required
			All lielus required
Source of Income	Current Monthly Gross income (Guarantor)*	Current Monthly Gross income (Spouse/other)*	Total Family Income*
Wages/Self Employment, Child Support/Alimony			
Social Security, Pension, Dividends, Interest, Rental Income			
Unemployment, Workers Compensation			
	Grand Total Famil	y Income:	
*If you reported \$0 in	ncome, please provide a brie	ef description of how basic livi	ng needs are being met
COME CERTIFICATION			
		ue and I acknowledge that provid	
		nay be considered to receive. In	
		the purposes of obtaining goods ion given above is accurate. Orla	
		there is a subsequent recovery	
,		,	
tness Signature:		Date:	Time:
•			
tness Printed Name:			
uarantor Signature:		Date:	_ Time:
-			
uarantor Printed Name:			

All fields on this document must be completed in order for your application to be reviewed