ORLANDO HEALTH®
P.O. Box 560176, Orlando, Fl. 32856
FinancialAssistance@orlandohealth.com
Phone: (321) 843-8955 Fax: (321) 843-1532

LINE UP PATIENT I.D. LABEL HERE

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.

Patient Name: _____

Patient Relationship to Guarantor: _____

GUARANTOR INFORMATION

Guarantor Name:_____ **Date of Birth:** _____

SSN/TIN: _____ **Self Employed: Yes_____ No____**

Disabled: Yes___ No___ **Marital Status: M___ S___ D___ W___** **Homeless: Yes_____ No____**

Address:_____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

All fields required

Are you a US Citizen, or a legally permitted individual?*: Yes___ No___

* Financial Assistance can only be offered to US Citizens with valid a Social Security Number or a legally permitted out of country resident with a government issued Tax Identification Number (TIN)

1. In the past 12 months, have you applied for: (circle all that apply)

Medicaid	Social Security Disability	County Medical Assistance	Workers Compensation	Health Exchange Marketplace	OTHER	NONE

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

All fields required

Household Member	Relationship to Guarantor	Date of Birth	Tax Filing Status *(select Individual, Joint, Not Filing)*

Total # of household members: _____

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3. HOUSEHOLD/FAMILY INCOME Provide income for yourself, your spouse and all other family members (if applicable)

All fields 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 Family Income: _____

***If you reported $0 income, please provide a brief description of how basic living needs are being met**

_____

_____

INCOME CERTIFICATION

I attest all of the information stated above is correct and true and I acknowledge that providing false information in this form may invalidate any or all financial assistance for which I may be considered to receive. In accordance with Florida Statute 817.50 providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor in the second degree and I attest to the fact that the information given above is accurate. Orlando Health reserves the right to change any decision made in reliance of this form for which there is a subsequent recovery of monies.

Witness Signature: _____ Date: _____ Time: _____

Witness Printed Name: _____

Guarantor Signature: _____ Date: _____ Time: _____

Guarantor Printed Name: _____

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

COMMUNICATION ASSISTANCE PROVIDED (Please Print)		
QUALIFIED INTERPRETER	**QUALIFIED BILINGUAL TEAM MEMBER**	**ASSISTING VISUALLY IMPAIRED**
Team Member Name & I.D.: _____	Team Member Name & I.D.:	Team Member/Reader Name & I.D.:
Agency/Interpreter Name and/or I.D.: _____	_____	_____
☐ Video remote ☐ Tel ☐ In-person Language: _____	Language: _____	Other: _____