Miami Jewish Health

FINANCIAL ASSISTANCE APPLICATION

Miami Jewish Health's Financial Assistance Program helps people who are unable to pay all of their hospital medical bills. You may qualify for discounts on medical care through the Program if:

- You do not have health insurance
- Your health insurance does not cover all of the medical care you need
- You are not eligible for Medicaid or some other type of insurance
- You meet the financial criteria

Application Completed by: ____ Date: __________________

Please Mark Line **N/A** if non-applicable

Patient Name: ____ DOB: ______/_______/__________

Address: ____ Patient Income: $___________per ___________

Spouse Income: $___________per ___________

Spouse/Guardian Name: ________________________________ Income Type ________________________

Phone #: Home (______)____________________Cell (________)__________

Responsible Person ___________________________________ Citizenship (please check)

Employer: ____ U.S. Citizen Y / N

Spouse/Employer: _____________________________________ Immigrant/non-citizen _________

Number of members in the family: ______________ Non immigrant Visa Holder _________

Other ___________

Other income including SSI/Social Security/Child Support payments:

Who receives the income______________________Source____________Gross Amount $__________per __________

Please check the appropriate statement boxes. Attach copies of DCF notice including attachments

Medicaid Statement

1. I/We ([ ] **have** / [ ] **have not**) applied for Medicaid to cover these services.
If not, please explain reason: ____

2. I/We ([ ] have / [ ] have not) been rejected by Medicaid
Reason for reject: Include a copy ____

3. I/We received an approval from Medicaid, but with a monthly spend down of $ __________

I understand that this application for Financial Assistance is confidential and will be used to determine my eligibility for uncompensated services under the Financial Assistance guidelines established by Miami Jewish Health. If any information that has been given proves to be untrue, I understand that Miami Jewish Health may re-evaluate my financial status and take whatever action becomes appropriate.

Signature of responsible party:____Date: ____________________

PLEASE PROVIDE ONE OF THE FOLLOWING DOCUMENTS

- Last 3 consecutive paystubs
- Most recent Tax Return
- Most recent Social Security Statement

In all cases photo ID or other legal identification

RETURN TO:
MIAMI JEWISH HEALTH SYSTEMS
ATTN: ADMISSIONS DEPARTMENT
5200 NE 2ND AVE
MIAMI, FLORIDA 33137

2018 Charity Care Schedule

Charity Care % Allowance	Household Size	% of FPL	One Person	Two Persons	Three Persons	Four Persons	Five Persons	Six Persons
	FPL - Annual Gross Income		12,140	16,460	20,780	25,100	29,420	33,740
	Monthly Gross Income		1,012	1,372	1,732	2,092	2,452	2,812
100%		up to 200%	24,280	32,920	41,560	50,200	58,840	67,480
			2,023	2,743	3,463	4,183	4,903	5,623
80%		201-250%	30,350	39,825	50,225	60,625	71,025	81,425
			2,529	3,319	4,185	5,052	5,919	6,785
60%		251-300%	36,420	49,380	62,340	75,300	88,260	101,220
			3,035	4,115	5,195	6,275	7,355	8,435
40%		301-350%	42,490	57,610	72,730	87,850	102,970	118,090
			3,541	4,801	6,061	7,321	8,581	9,841
20%		351-400%	48,560	65,840	83,120	100,400	117,680	134,960
0%		Over 401%						

For Office Use Only:

Date Received in Business Office:____/_____/____ By: __________________________________

Approved By:___________________________________ Rejected By: ___________________________________

Reason: ____

Applicant advised on_________/_______/________by [ ] *phone* [ ] *letter* [ ] *in person*

An account for $_________________________for______________payments established