TGH Tampa General Hospital

Application for Assistance with Hospital Expenses

To be completed by hospital staff:

Patient Name:____

Account Number:______________________________ Date of Service:____________________

	Credit Code E	Credit Code F	Credit Code H
Family Size	Annual Income	Annual Income	Annual Income
1	0 - $11,770	$11,771 - $17,655	$17,656 - $23,540
2	0 - $15,930	$15,931 - $23,895	$23,896 - $31,860
3	0 - $20,090	$20,091 - $30,135	$30,136 - $40,180
4	0 - $24,250	$24,251 - $36,375	$36,376 - $48,500
5	0 - $28,410	$28,411 - $42,615	$42,616 - $56,820
6	0 - $32,570	$32,571 - $48,855	$48,856 - $65,140
7	0 - $36,730	$36,731 - $55,095	$55,096 - $73,460
8	0 - $40,890	$40,891 - $61,335	$61,336 - $81,780
For each additional person add	$4,160	$4,160	$4,160

	Credit Code J	Credit Code K
Family Size	Annual Income	Annual Income
1	$23,541 - $47,080	$47,081 or greater
2	$31,861 - $63,720	$63,721 or greater
3	$40,181 - $80,360	$80,361 or greater
4	$48,501 - $97,000	$97,001 or greater
5	$56,821 - $113,640	$113,641 or greater
6	$65,141 - $130,280	$130,281 or greater
7	$73,461 - $146,920	$146,921 or greater
8	$81,781 - $163,560	$163,561 or greater
For each additional person add	$4,160	$4,160

NOTE: Additional information and proof of income may be required before a final determination is made by the hospital.

In the event that your injuries or illness, which necessitated the services rendered by Tampa General Hospital, arose from the acts or omission of a third party and you are entitled to compensation from that third party or their insurer, then the aforementioned charity entitlement is null and void. Tampa General Hospital, as the holder of the assignment of benefits is entitled to be reimbursed for services rendered directly from any settlement or judgment proceeds. Failure to advise Tampa General Hospital of any third party settlement or judgment will result in the revocation of the charity entitlement.

The financial information that you provide may be verified by Tampa General Hospital. Falsification of this information is against state law and will result in the revocation of any discount and/or charity adjustment granted, thus making the total balance your responsibility.

I authorize the hospital and/or contractor to act on my behalf for the purposes of obtaining insurance coverage or replacement medications.

I understand that providing false information to defraud a hospital for the purpose of obtaining goods or services is a MISDEMEANOR in the second degree and punishable under FLORIDA STATUTE 817.50. I certify the above information is true and accurate to the best of my knowledge.

____ ____________________

Signature of Patient or Parent of Minor Patient or Patient's Legal Guardian — Date

____ ____________________

Printed Name of Patient or Parent of Minor Patient or Patient's Legal Guardian — Signature of Witness

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Worksheet

Regarding Credit Code X

Please note that credit code X is intended to be a temporary holding designation which requires follow-up or documentation as to why follow-up has not been possible. In the work space below, please indicate the special circumstance, which prevented the gathering of data sufficient to assign a permanent credit code assignment.

At the time of Admission /Registration the patient was unable to provide the necessary information because:

__________________Patient's confused and does not comprehend the question or document.

__________________Patient's injuries prevent access for questioning (i.e. trauma).

__________________Patient's medical condition prevents access for questioning (i.e. comatose).

__________________Physicians / Nurses request: or direct that patient cannot be accessed for questioning.

__________________Patient taken directly to surgery, floor or diagnostic setting.

__________________Patient is deceased.

__________________Other____

Follow-up attempts to gather required information from patient and or family was made.

__________________	__________	____________________	__________________
Date	**Time**	**Location**	**By**

Patient/Guarantor Statement

___________I choose not to provide any information on my personal finances or family size.

________________	_____________	______________________________
Date	**Time**	**Location**

____

Patient / Guarantor Signature