SPACE COAST HEALTH CENTERS INC.
A Florida not-for-profit corporation

Account # ______________________
Adults in Household ______________________
Dependents in Household ______________________
Yearly Gross Income ______________________

If you need help filling out these forms, please let us know.

PATIENT INFORMATION

Patient Last Name ______________________ First Name ______________________ Middle ________

Mailing Address ______________________ City ______________________ State ______ Zip __________

Phone # ______________________ Social Security # ______________________ DOB __________ Age __________

Email Address ______________________ Primary Language ______________________ Marital Status __________

Spouse Last Name ______________________ First Name ______________________ Middle ________

Phone # ______________________ Social Security # ______________________ DOB ________ Age __________

GUARANTOR INFORMATION

Person Responsible for Payment (other than Insurance Company)

Guarantor Last Name ______________________ First Name ______________________ Middle ________

Relation to Patient ______________________ Phone # ______________________

Mailing Address ______________________ City ______________________ State ______ Zip __________

HOUSEHOLD INFORMATION

For additional dependents, please list on the back of this page.

ADULTS (First & Last Names)	**RELATIONSHIP**	**DOB**	**AGE**

DEPENDENTS (First & Last Names)	**RELATIONSHIP**	**DOB**	**AGE**

EMPLOYMENT

Patient's Place of Employment ____________________ Phone # ____________

Spouse's Place of Employment ____________________ Phone # ____________

Guarantor's Place of Employment ____________________ Phone # ____________

STATE & FEDERAL ASSISTANCE

Are you pregnant? ☐ Yes ☐ No

Do you have minor children? ☐ Yes ☐ No

Have you applied for or are receiving Medicaid, Medically Needy, or other state/federal assistance? ☐ Yes ☐ No

Are you disabled or receiving Social Security Disability Insurance (SSDI)? ☐ Yes ☐ No

Do you qualify for Medicaid? ☐ Yes ☐ No

Do you qualify for any other state or federal programs? ☐ Yes ☐ No

MONTHLY INCOME		MONTHLY EXPENSES	
Are you self-employed or own your own business? ☐ Yes ☐ No		*If yes, please provide financial statements with application.*	
Employment: You	$	Rent	$
Employment: Spouse	$	Mortgages	$
Employment: Guarantor	$	Electric/Gas	$
Employment: Other Family Member	$	Water	$
Unemployment	$	Child Care	$
Social Security	$	Health Insurance	$
Veteran Administration	$	Medical Bills	$
Child Support	$	Credit Cards	$
Rental Income	$	Car Payments	$
Real Estate	$	Car Insurances	$
Work Comp	$	Telephone	$
Other (List type)	$	Cable TV	$
Other (List type)	$	Internet	$
Other (List type)	$	Food	$
TOTAL MONTHLY INCOME	**$**	**TOTAL MONTHLY EXPENSES**	**$**

LIQUID ASSETS	
	Balances
Name of Bank/Credit Union	
Savings Account	$
Checking Account	$
Other (List type)	$
Other (List type)	$
TOTAL LIQUID ASSETS	

NON-LIQUID ASSETS	
	Balances
Real Estate	$
2nd Automobile	$
Boat	$
Life Insurance	$
Loans	$
Stocks	$
Bonds	$
CDs	$
Other (List type)	$
Other (List type)	$
** Value of 1st Automobile	$
** Value of Homestead	$
TOTAL NON-LIQUID ASSETS	**$**

TOTAL ASSETS (Add Liquid Assets and Non-Liquid Assets)	**$**

LETTER OF SUPPORT

By signing this letter of support, this in no way obligates you for the patient's bills.

I, ______________________________ provide room and board and/or financial assistance

for ______________________________ .

Signed by ______________________________

Relationship ______________________________ Date/Time ______________

PROOF OF INCOME

Proof of income must accompany this application.
By signing this letter of support, this in no way obligates you for the patient's bills.

I, ______________________________ certify that my family income for the past 12 months

has been $ ______________ and can be verified by contacting the following employer(s):

Company ______________________________ Phone ______________

Company ______________________________ Phone ______________

I hereby authorize Space Coast Health Centers to verify the information on this application by whatever means necessary.
I further understand that this could mean contacting my employer, my bank, or running a credit report.

I understand that in order to be eligible for this program, I must be willing to apply for any and all state and federal programs or private sources available to pay this bill. I also understand that this application can be re-evaluated at any time if Space Coast Health Centers finds it necessary.

Further, I hereby certify that the information given by me on this application is true and accurate. In the event that any information given by me on the application changes, I agree to promptly notify Space Coast Health Centers.

SIGNATURES

Patient ______________________________ Date ______________

Guarantor ______________________________ Date ______________

Spouse ______________________________ Date ______________

Witness ______________________________ Date ______________