SCS ☐ **HCRA** ☐

State of Florida, Agency for Health Care Administration

HEALTH CARE ASSISTANCE APPLICATION

In-County ____
Out-of-County ____

Applicant's County of Residence ____________

PART 1 - HOUSEHOLD INFORMATION - To Be Completed By Applicant

Name: First, Middle, Last	Social Security Number	Date of Birth	Relationship to Applicant	Health Insurance or 3rd Party Coverage	Blind	Disabled	Pregnant	Agency Referred To
			PATIENT	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
				Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
				Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
				Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
				Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
				Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
				Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Living Address:

Mailing Address:

Previously Hospitalized in Florida in Last Year? ☐ Yes ☐ No If yes, Where:

Phone Number: ( )

Shelter Situation: ☐ Rent ☐ Buy ☐ Own ☐ Other

U.S. Citizen? ☐ Yes ☐ No

Alien Regisgration No.:

PART 2- FINANCIAL INFORMATION - To Be Completed By Applicant

INCOME EXAMPLES	TYPE	WHO HAS	GROSS AMOUNT	HOW OFTEN	ASSETS EXAMPLES	TYPE	WHO HAS	VALUE
Wages, Self-Employment, Social Security, Child Support Contributions, Unemployment Compensation, Railroad Retirement, SSI, AFDC			$		Cash, Checking account, Car/truck, Motorcycle, Burial insurance, Trust funds, Life insurance, Burial plot, Real estate, Business equipment, Boat, Stocks/Bonds, Savings			$
			$					$
			$					$
			$					$
			$					$
		TOTAL INCOME	$				TOTAL ASSETS	$

PART 3 - DECLARATION

I am applying for assistance. I understand that I will have to give true information on this form. It could be a crime if I am not truthful about my eligibility for assistance.
I agree to turn in papers that are required to show that I am eligible, except for papers I cannot get through no fault of my own. If I cannot get papers, I agree to give the names of persons or places that may be contacted for the required information
I agree to apply for any other medical assistance program I may be eligible for.
I agree that the Agency for Health Care Administration or the county may verify the information I give on this form and at my interview. I agree that they may contact my present or past employers, if it relates to my eligibility. I agree that they can get information that affects my eligibility from any records.

Signature ____________ Date ____________ Spouse's or Representative's Signature ____________ Date ____________

PART 4- PATIENT INFORMATION - To Be Completed by Hospital Personnel

Date Admitted or Services Provided:

Date of Discharge:

Patient Account No.:

Deceased: Yes ☐ No ☐ Date:

Case Mgmt. Agency: ☐ Enrolled ☐ Referred Date:

Previously Hospitalized in this hospital in Last Year? ☐ Yes ☐ No

If yes, When:

InPatient: ____ OutPatient $

Days Total Charge

PART 5 - REFERRAL HOSPITAL - To Be Completed By Hospital Personnel

Referral Hospital: ____________

Hospital HCRA ID #: ____________

Address: ____________

Date Sent To County: ____________

Signature: ____________

Print Name: ____________ Phone Number: ( ) ____________

Charity Obligation Met? Yes ☐ No ☐

PART 6 - COUNTY/AGENCY USE

WORKER:

Name

( )

Phone Number

Application Approved:

Yes ☐ No ☐

DATE STAMP

AHCA Form 5220-0001 December 1998/HCRA

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When entering a date - Please use the MM/DD/YYYY format, example: 06/15/1961.
When entering dollar amounts - do not use a comma.

Use the tab key to navigate the form.

INSTRUCTIONS TO PATIENT/APPLICANT

- We would like you to fill out as much of Part 1 and Part 2on the front as you can. If you cannot fill it out, a hospital worker will help you.
- In Part 1, list your name first and then list the names of all relatives that live with you.
- DO NOT write in Parts 4, 5, and 6. These are for office use only. DO NOT write on the back of this form.
- In order for this form to count as an application for assistance in paying your hospital bill, you must read, sign and date Part 3 on the front. Be sure to fill in your address so we can contact you about an interview should we need to request additional information.
- Return ALL COPIES of this form to a hospital staff person.

INSTRUCTIONS TO HOSPITAL WORKER

- Complete Part 1 and Part 2 for the patient/applicant unless the patient/applicant wants to do it.
- Assist the patient/applicant in obtaining all necessary vertifications.
- Give the YELLOW copy of the form to the patient/applicant.
- Complete Part 4 and Part 5. Sign Part 3 if the patient is unable to sign or if the hospital is acting as the patient's representative.
- Send the WHITE copy to the certifying agency for processing with all verification obtained.
- Retain the PINK copy for your records.

INSTRUCTIONS TO CERTIFYING AGENCY

- Date stamp in Part 6 upon receipt.
- Determine whether all necessary verification has been provided.
- Schedule an interview with the patient/applicant to obtain additional information if necessary.
- Determine eligibility.
- Notify patient/applicant and referring hospital of decision.