☐ 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	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
Wages, Self-Employment, Social Security, Child Support Contributions, Unemployment Compensation, Railroad Retirement, SSI, AFDC			$	
			$	
			$	
			$	
			$	
		TOTAL INCOME	$	

ASSETS			
EXAMPLES	TYPE	WHO HAS	VALUE
Cash, Checking account, Car/truck, Motorcycle, Burial insurance, Trust funds, Life insurance, Burial plot, Real estate, Business equipment, Boat, Stocks/Bonds, Savings			$
			$
			$
			$
			$
		TOTAL ASSETS	$

PART 3 - DECLARATION

I am applying for assistance. I understand that, in addition to completing this form, I may have to provide accurate sources of information and verification in regards to eligibility requirements. I understand I may be asked for an interview and am expected to keep appointments. I agree to apply for any other medical assistance program I may be eligible for. I authorize release of such eligibility determination information to the certifying agency as deemed necessary in connection with my application. I understand that I may have a share of cost that I will be responsible to pay to the hospital. It could be a crime if I am not truthful about my eligibility for assistance. Should it be determined that fraud was committed or incorrect information was intentionally provided, resulting in an inappropriate eligibility determination, I will be responsible for repaying any amounts paid on my behalf.

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, February 2016

Section 59H-1.0035(20), Florida Administrative Code

Form available at: http://www.ahca.myflorida.com/MCHQ/Central_Services/Financial_Ana_Unit/HCRA/index

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.