BROOKS Rehabilitation

Patient Financial Disclosure Instructions

Attached is a Financial Disclosure that will help us determine if you are eligible for financial assistance.

Brooks Rehabilitation bases your eligibility for this program on the State of Florida Agency for Healthcare Administration (AHCA). (See Enclosed Form).

This program is designed to help patients who have little or no health insurance.

If you are interested in applying for assistance, please complete this form, attach proof of income, and return to your Brooks Rehabilitation Representative. Upon receipt of all required information, we will review for eligibility and notify you of the determination.

All information submitted in this application will be kept confidential and will only be used for the financial purposes stated above.

We cannot process your application for financial assistance without the following completed forms attached hereto:

- **Financial Assistance Disclosure Form page (Page 2)**
- **Completed Financial Disclosure Form (Page 3 & 4)**
- **Signed Request for Uncompensated Services (Guideline Letter) (Page 5)**
- **Proof of HOUSEHOLD income:** ***Proof of income is required for ALL individuals 18 and older living in the home. A minimum of ONE of the following listed below is REQUIRED***

Recent 3 – Work Check Stubs	Recent 3 – Bank (Checking) Statements	SSI/Disability
2023 W2 Forms	2023 Tax Returns	Unemployment
SSA.Gov	Medicaid	

If you have any questions, please feel free to contact the Business Office at the number listed below.

Sincerely,

Inpatient	**Outpatient**	**Physician Practice**	**Home Health**	**Bartram SNF**	**University SNF**
Business Office	Business Office	Business Office	Business Office	Business Office	Business Office
(904) 345-7630	(904) 902-3887	(904) 345-7373	(904) 306-9729	(904) 528-3017	(904) 345-8326

BROOKS Rehabilitation

FINANCIAL ASSISTANCE DISCLOSURE FORM

Brooks Financial Assistance program is designed to help patients who have little or no health insurance to cover the cost of their rehabilitation. Services rendered under the Financial Assistance program are short-term solutions to bridge the gap between insurance and the patient's needs. It is not intended to support long-term care and is provided as the last option.

Brooks determines your eligibility for this program based on medical necessity and on financial need*. The Financial Assistance Disclosure Form will help us determine if you are eligible for aid from Brooks and the amount you are eligible to receive. All information you submit is confidential and will be used for this purpose only. It will not be shared with any outside party.

Please complete the attached form and return the application and copies of proof of income (identified on the application form) to your Brooks Representative where you are being treated. The sooner you submit your completed application, the sooner we will be able to process the information and determine eligibility. Please remember that you will be responsible for all payments prior to determination of Brooks Financial Aid eligibility, so it is to your advantage to submit the completed forms as soon as possible.

Patient Responsibility if Approved for Brooks Financial Assistance:

- If you are required to pay an amount toward your treatment, you will be asked to pay for your portion prior to or at the time of service.
- You must contact us ASAP if you cannot make a scheduled appointment. If you do not contact us and/or cancel two times, you will be discharged immediately.
- You must continue to meet medical necessity requirements throughout the rehabilitation program. This means that the patient is making significant progress in a reasonable period of time. The financial assistance committee periodically reviews patients' progress to determine if they are showing improvement. If a patient's therapy progress has slowed or reached a plateau, they may be discharged from the Brooks Financial Assistance program.
- You must inform us if your income or insurance changes during treatment or if similar services can now be received in the school or at another type of facility. You may be asked to fill out a new application, which will be reviewed by the financial assistance committee.
- No services will be covered under Financial Assistance for Non-US Citizens.
- Outpatient Only: If you are 21 years of age or older, you will be asked to submit a new application every 3 months. If you or your dependents are under 21, you will be asked to submit a new application every 6 months.
- **Please be aware that if you are in the legal process of obtaining a settlement for an automobile accident or other claim then Brooks will file a lien with your attorney for services to be paid upon settlement.**

Please provide your attorney's name and phone number:

_____.

Please allow one week for processing of your application. If you have any questions, you may contact your Brooks Rehabilitation Representative or call our customer service line at (904) 902

Signature: _____ **Date:** _____

BROOKS Rehabilitation

PERSONAL INFORMATION

Patient's Name _____

Home Address _____

Social Security # _____ D.O.B. _____ Age _____

Home Phone _____ Cell _____

Check One: ☐ Actively Employed ☐ Retired ☐ Disabled ☐ Unemployed

Employer _____ Length of Employment _____

Employer Addr. _____

Business Phone _____ Occupation _____

Hourly Wage _____

Total Monthly Income _____ (submit ALL proof of income)

All Other Income (Gross) _____ (Submit proof Alimony/Child Support, Etc.)

Parent/Spouse Name _____

Home Address _____

Social Security # _____ D.O.B. _____ Age _____

Home Phone _____ Cell _____

Check One: ☐ Actively Employed ☐ Retired ☐ Disabled ☐ Unemployed

Employer _____ Length of Employment _____

Employer Addr. _____

Business Phone _____ Occupation _____

Hourly Wage _____

Total Monthly Income _____ (Submit ALL proof of income)

All Other Income (Gross) _____ (Submit proof Alimony/Child Support, Etc.)

HOUSEHOLD INFORMATION

Please list any and all individuals living in your home (including patient)

Name _____ Relationship _____ Age _____ Employed? _____

Name _____ Relationship _____ Age _____ Employed? _____

Name _____ Relationship _____ Age _____ Employed? _____

Name _____ Relationship _____ Age _____ Employed? _____

Name _____ Relationship _____ Age _____ Employed? _____

Name _____ Relationship _____ Age _____ Employed? _____

Total Number in Household _____

*****Applications cannot be approved without proof of income and signatures**

BROOKS Rehabilitation

GENERAL ASSESSMENT INFORMATION

Check one answer for each of the following questions:

1. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other
2. Do you have insurance? ☐ No ☐ Yes If yes, what insurance? _____
3. Are you eligible for Cobra or insurance benefits from employer? ☐ No ☐ Yes ☐ N/A
4. Have you applied for Medicaid? ☐ No ☐ Yes When? _____
5. Do you have any pending lawsuits? ☐ No ☐ Yes
6. If **YES** to # 5, please provide your Attorney's Name & Phone Number:
   _____
7. Have you received any settlements? ☐ No ☐ Yes
8. Are you a natural born citizen? ☐ No ☐ Yes
9. Where were you born? _____
10. Are you a US Citizen? ☐ No ☐ Yes
11. Do you have valid Work/Student Visa? ☐ No ☐ Yes
12. Do you own home? ☐ No ☐ Yes Approx. Value _____
13. Are you renting? ☐ No ☐ Yes How Long? _____
14. Do you own other property? ☐ No ☐ Yes Approx. Value _____
15. ***Please include a copy of state issued picture identification with your application.***

HOUSEHOLD CREDIT/EXPENSE INFORMATION

List All Debt Owed	Company Name	Total/Present Balance	Monthly Payment
Mortgage/Rent			
Car Payment			
Credit Card			
Credit Card			
Food			
Electric			
Phone			
Prescription/Medicines			
Cable			
Other			

"The undersigned hereby acknowledges the information provided in this financial statement to be true and correct to the best of my (our) knowledge. By signing this financial statement, I (we) hereby authorize to inquire into my (our) credit history and to contact my (our) employer(s) for verification of income. I (we) further authorize my (our) employer(s) to supply to Brooks Rehabilitation information verifying my (our) income, upon presentation by Brooks Rehabilitation of a copy of this financial statement."

Patient or Responsible Party Signature _____ **Spouse's Signature (if applicable)** _____

BROOKS Rehabilitation

Request for Determination of Eligibility for Uncompensated Services

I, herein, request that Brooks Rehabilitation make a determination of my eligibility for uncompensated services. I understand that the information I submit is subject to verification.

Eligibility is based on the State of Florida Agency for Health Care Administration (AHCA) guidelines as follows:

> No patient will be considered a charity/uncompensated care patient whose family income as applicable for the twelve (12) months preceding the determination exceeds two hundred (200) percent of the current federal poverty guidelines (below) unless the amount of the charge due from the patient exceeds twenty-five (25) percent of the annual family income. However, in no case shall the charges for a patient whose family income exceeds four (4) times the federal poverty level for a family of four (4) be considered charity.

2024 FEDERAL POVERTY GUIDELINES

Federal Poverty Guidelines		**One or More Must Be Provided to Support This Request**
Family Size	2024 Federal Income Guidelines	1) **Income Tax Returns** (Prior year signed, completed, tax returns for entire household) 2) **W-2 withholding forms** (Most recent W2 forms for entire household) **3) SSI/SSD Letter** **4) Recent 3 bank statements** (for entire household, if applicable) ***************Proof of income is required for all members of household 18 and older**************
1	$15,060	
2	$20,440	
3	$25,820	
4	$31,200	
5	$36,580	
6	$41,960	
7	$47,340	
8	$52,720	

Federal Guidelines for each additional person, add $5,140

I hereby certify that I qualify for the uncompensated service based upon the AHCA guidelines listed above.

Date _____

Patient/Guarantor Signature_____

Witness _____

** Florida State Statute 817.50 – Fraudulently obtaining goods, services, etc. from hospital – (1) whoever shall, willfully and with intent to defraud, obtain or attempt to obtain, goods, products, merchandise or services from any hospital in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in SS775.082 or SS775.083.