NSU Florida
HEALTH CLINICS

FINANCIAL HARDSHIP INCOME DETERMINATION FORM

CLINICAL SERVICE: ____

PATIENT TYPE: [ ] NEW PATIENT [ ] ESTABLISHED PATIENT

PATIENT:
Last Name: ____
First Name: ____
Social Security Number: ____
Address: ____
City: ____________________ State: ____________________ Zip: ______________
DOB: ____/____/_____ Sex: M [ ] F [ ] Phone: (___) _________________

GUARANTOR:

Name: ____
Relation: ____
Number of Dependents: ____

PROOF OF INCOME: (To be completed by patient or legal guardian)
Earned Income for the Family Unit:
(Family members who are employed and their monthly income)

NAME	EMPLOYER	GROSS ANNUAL INCOME
		$
		$
		$
		$
SUBTOTAL		**$**

Unearned Income for the Family Unit: (Household income from the following sources)

Child Support $	AFDC $
Alimony $	Unemployment $
Worker's Comp. $	Social Security $
Other $	**SUBTOTAL** **$**

TOTAL INCOME: $____________________

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CERTIFICATION:

I certify under penalty of perjury that the above information is a true and complete statement of my financial situation to the best of my knowledge. I understand that the information I have given is subject to verification by Nova Southeastern University. I understand that knowingly falsifying information may result in civil and criminal penalties and a withholding of services.

_______________________________________ _______________________________
Signature (Patient or Legal Guardian) Date

VERIFICATION: (To be completed by NSU personnel only)

1. Medicare [ ] #___________________________________
   Medicaid [ ] #___________________________________

2. Third party insurance [ ] Carrier Name: ____
   Member ID # ______________________ Group # ________________________Verification [ ]

3. Patient has exhausted their insurance benefits? [ ] Date _______/_______/________

4. Approved Supporting Document:____

By NSU Employee Name/Title:

____

NSU Employee Signature _____________________________ Date: _______/_______/________

NSU Clinical Dyad Leader Signature:

____

PROFESSIONAL FEE ONLY FINANCIAL HARSHIP DISCOUNT APPROVED:

Approved Discount _________________% Expiration Date: _______/_______/________

Approval Signature__________________________________ Date: _______/_______/________

Name/Title __________________________________ / __________________________________

NSU Florida
HEALTH CLINICS

FINANCIAL HARDSHIP COVER SHEET

CLINICAL SERVICE: ____

PATIENT TYPE: [ ] NEW PATIENT [ ] ESTABLISHED PATIENT

PATIENT:
Last Name: ____
First Name: ____
Social Security Number: ____
Address: ____
City: ____________________ State: ____________________ Zip: ______________
DOB: ____/____/_____ Sex: M [ ] F [ ] Phone: (___) _________________

PROFESSIONAL FEE ONLY FINANCIAL HARSHIP DISCOUNT APPROVED:

Approved Discount __________________% Expiration Date: _______/_______/________

Approval Signature___________________________________ Date: _______/_______/________

Name/Title ___________________________________ / ___________________________________