Information Needed For Your Financial Assessment Appointment

We believe that every person living in Miami-Dade County has a right to health care that they can afford. To determine if you qualify for any of our medical financial assistance programs, we ask for information that explains your citizenship/residency, gross income, size of family unit, and that you have lived in Miami-Dade for at least 90 days.

Financial Assessment Locations
You can have your assessment at any of these convenient locations when scheduling your financial assessment:
- Dr. Rafael A. Peralta Clinic
  971 N.W. 2nd Street, Miami
- Jackson Memorial Hospital
  1611 N.W. 12th Avenue, Miami
- Jackson South Community Hospital
  4950 S.W. 152nd Street, Suite 104, Miami
- Jefferson Reaves, Sr. Health Center
  1009 N.W. 5th Avenue, Miami
- North Dade Health Center
  16555 N.W. 25th Avenue, Miami Gardens
- Rosie Lee Wesley Health Center
  9601 S.W. 62nd Avenue, South Miami

Proof That You Live In Miami-Dade County
Please bring:
- Two current documents with your name and address dated within 30 days.
- One document with your name and address dated greater than 90 days.

The following documents may be used to meet the above requirements:
- Voter registration card
- Florida driver's license, valid Florida identification card or other ID card showing a Miami-Dade County address or vehicle registration in the name of the patient, spouse or partner
- Mortgage, lease or rental receipt dated at least 90 days prior to appointment date, if the home is paid in full, a deed or a mobile home title and registration
- Water, electric, telephone or other utility bill in the name of the patient, spouse or partner showing the current home address
- A letter from the government mailed to the patient's home address
- Proof of school enrollment for children living in the home
- Recent historical record of Miami-Dade County residence documented through a county department's case record
- Other documents that provide evidence that the patient lives in the county

Proof Of Income
- Gross income for the last 30 days of each wage earner in the family
- Most recent income tax form(s), if self-employed, bring IRS Schedule C (Net Income) and/or work calendar
- Letter from employer on company letterhead verifying gross weekly, bi-weekly or monthly income
- Pension statement or check stub
- Social Security award letter
- Proof of rental income
- Unemployment Compensation income
- Worker's Compensation income
- Child support and alimony income

Insurance/Annuity Payments
- College scholarships and grants
- Dividend interest income
- Letter of monetary support from the supporter with length of time and monthly support amount and signature
- Letter of room and board support from the supporter with length of time support has been provided

Other Important Information
- Proof of current monthly expenses within 30 days (rent or mortgage receipt, car payment, loan payment, credit card, utilities)
- Proof of application or benefit denial for unemployment compensation, Medicaid, Social Security, disability, public assistance, etc.
- Proof of dependents (such as tax return, birth certificate or legal guardianship)
- Bank or federal deposit verification and statement
- Marriage certificate
- Social Security card

www.JacksonHealth.org
PERSONAL STATEMENT FORM

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION
I certify that the information provided to complete this application is true. Additionally, I understand that in accordance with statute 817.50, providing false information to defraud a hospital for the purpose of obtaining goods and services, including pharmacy items, is a misdemeanor in the second degree.

MR# __________________

I, ________________________, declare

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

_________________________________________  ___________________________________________  ____________
Patient/Representative Signature          Patient/Representative Printed Name          Date

_________________________________________  ___________________________________________  ____________
Other Signature / Relationship            Other Printed Name                            Date

_________________________________________  ___________________________________________  ____________
Enrollment Specialist Signature          Enrollment Specialist Printed Name             Date Form Received
EMPLOYMENT VERIFICATION STATEMENT

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information provided to complete this application is true. Additionally, I understand that in accordance with statute 817.50, providing false information to defraud a hospital for the purpose of obtaining goods and services, including pharmacy items, is a misdemeanor in the second degree.

MR# _______________________

EMPLOYMENT – Please complete the section that applies to you.

UNEMPLOYED

☐ I, ____________________________, certify that I am unemployed.

Last date of employment: ______ / ______  OR  ☐ I have never been employed.

Month  Year

SELF-EMPLOYED

☐ I, ____________________________, certify that I am self-employed.

Describe the work you do: _____________________________________________________________

Self-Employed with no income documentation (Complete this only if you are paid in cash or if you do not receive checks to document your income.)

☐ I am providing a letter from my employer.
☐ I am providing IRS Schedule C (form 1040) – Profit or Loss from Business.
☐ I am providing my work calendar with amount(s) paid.
☐ I am unable to obtain any of the above documents. Explain why: __________________________

List your income for last four weeks:

<p>| | | | |</p>
<table>
<thead>
<tr>
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<tbody>
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<td>(1) $</td>
<td>(2) $</td>
<td>(3) $</td>
<td>(4) $</td>
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</table>

Patient/Representative Signature ________________  Patient/Representative Printed Name ________________  Date ________________

Signature/If needed for other family unit member ____________________________  Printed Name ____________________________  Date ________________

JHS Representative Signature ____________________________  JHS Representative Printed Name ____________________________  Date Form Received ________________

Revised 06/2014
THIRD-PARTY SUPPORT AND VERIFICATION STATEMENT

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information provided to complete this application is true. Additionally, I understand that in accordance with statute 617.50, providing false information to defraud a hospital for the purpose of obtaining goods and services, including pharmacy items, is a misdemeanor in the second degree.

FINANCIAL SUPPORT

☐ I, __________________________, provided $__________ last month to the patient referenced below.

THIRD-PARTY SUPPORT OF LIVING ARRANGEMENT

☐ I, __________________________ (supporter), provide room and board and other support for the patient referenced below. The person does not pay rent to me. I must provide proof of address for verification purpose. I am providing the patient with a current expense bill or other household document for him/her to show you my current address.

THIRD-PARTY PAYMENTS to patient’s credit accounts

☐ I, __________________________ (responsible party), certify I am the person responsible for making the payments in connection to the following expense(s) which are in the name of referenced patient. I must provide proof of payments. Please send documented proof with patient to his/her financial assessment.

Expense Name: __________________________ Amount: __________
Expense Name: __________________________ Amount: __________
Expense Name: __________________________ Amount: __________

Reference Loan Type or Loan #: __________________________

Patient/Representative Signature __________________________

Patient/Representative Printed Name __________________________

Date __________________________

Third-Party Supporter Signature __________________________

Third-Party Supporter Printed Name __________________________

Date __________________________

JHS Representative Signature __________________________

JHS Representative Printed Name __________________________

Date Form Received __________________________

*Notary stamp and signature are required if third-party person is not present at time of Financial Assessment
# Jackson Health System Fees

**Effective September 1, 2012**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Clinics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J02/E02</td>
<td>急诊 100% per visit</td>
<td>-</td>
</tr>
<tr>
<td>J03/E03</td>
<td>急诊随访</td>
<td>$50</td>
</tr>
<tr>
<td>J04/E04</td>
<td>急诊</td>
<td>$80</td>
</tr>
<tr>
<td>P01/E01</td>
<td>急诊自付 $200 deposit</td>
<td>100% of charges *</td>
</tr>
<tr>
<td>N01</td>
<td>全价</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
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<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J02/E02</td>
<td>急诊 $6.50 per drug</td>
<td></td>
</tr>
<tr>
<td>J03/E03</td>
<td>急诊 $12 per drug</td>
<td></td>
</tr>
<tr>
<td>J04/E04</td>
<td>急诊 $25 per drug</td>
<td></td>
</tr>
<tr>
<td>P01/E01</td>
<td>急诊全价</td>
<td></td>
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<tbody>
<tr>
<td><strong>Emergency Department, Specialty Clinic &amp; Dental Evaluation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J02/E02</td>
<td>急诊</td>
<td>$40</td>
</tr>
<tr>
<td>J03/E03</td>
<td>急诊</td>
<td>$70</td>
</tr>
<tr>
<td>J04/E04</td>
<td>急诊</td>
<td>$100</td>
</tr>
<tr>
<td>P01/E01</td>
<td>急诊自付 $200 deposit</td>
<td>100% of charges *</td>
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<tbody>
<tr>
<td><strong>Clinics de Atención Primaria</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J02/E02</td>
<td>急诊 100% per visit</td>
<td>-</td>
</tr>
<tr>
<td>J03/E03</td>
<td>急诊随访</td>
<td>$50</td>
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<td>J04/E04</td>
<td>急诊</td>
<td>$80</td>
</tr>
<tr>
<td>P01/E01</td>
<td>急诊自付 $200 deposit</td>
<td>100% of los cargos *</td>
</tr>
<tr>
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<td>全价</td>
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<tbody>
<tr>
<td><strong>Farmacia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J02/E02</td>
<td>急诊 $6.50 por medicamento</td>
<td></td>
</tr>
<tr>
<td>J03/E03</td>
<td>急诊 $12 por medicamento</td>
<td></td>
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<td>J04/E04</td>
<td>急诊 $25 por medicamento</td>
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<td>P01/E01</td>
<td>急诊全价</td>
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<tr>
<td><strong>Departamento de Emergencias, Clínica Especializada, Evaluación Dental</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J02/E02</td>
<td>急诊</td>
<td>$40</td>
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<td>急诊</td>
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</table>

**Apati 1er Septa 2012**

(急诊部分POU CHAK SëVIS
pou randevou medikal, tès laborawat
woutin, ak radyografy woutin)

**Klinik Swen Primë**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>J02/E02</td>
<td>急诊 100% per visit</td>
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**Famasi**

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<tr>
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<th>Description</th>
<th>Price</th>
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<tbody>
<tr>
<td>J02/E02</td>
<td>急诊 $6,50 pou chak medikaman</td>
<td></td>
</tr>
<tr>
<td>J03/E03</td>
<td>急诊 $12 pou chak medikaman</td>
<td></td>
</tr>
<tr>
<td>J04/E04</td>
<td>急诊 $25 pou chak medikaman</td>
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**Depatman Ijans, Klinik pou Espesyalite & Evalyayson Dantë**

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</table>
Inpatient & Outpatient Procedures
(including Dental)**
(fee per day, up to 3 days)
J02/E02 $100 per day
J03/E03 $200 per day
J04/E04 $300 per day

Routine Lab Tests & Routine Radiology
J02/E02 $25
J03/E03 $50
J04/E04 $80
P01/E01 $90 deposit toward 100% of charges *
N01 Full Price

High-Cost Radiology, MRI, CT, PET, NM
J02/E02 $40
J03/E03 $70
J04/E04 $100
P01/E01 $200 deposit toward 100% of charges *
N01 Full Price

Rehabilitation, Infusion Therapy, Radiation Oncology
J02/E02 $15
J03/E03 $25
J04/E04 $40
P01/E01 $90 deposit toward 100% of charges *
N01 Full Price

Procedimientos de hospitalización y ambulatorios
(incluyendo dental)**
(tarifa por día; hasta tres días)
J02/E02 $100 por día
J03/E03 $200 por día
J04/E04 $300 por día

Exámenes de laboratorio y radiografías de rutina
J02/E02 $25
J03/E03 $50
J04/E04 $80
P01/E01 $90 de depósito para el 100% de los cargos *
N01 Precio completo

Radiografías de alto costo
J02/E02 $40
J03/E03 $70
J04/E04 $100
P01/E01 $200 de depósito para el 100% de los cargos *
N01 Precio completo

Rehabilitación, terapia de infusión, radiación oncológica
J02/E02 $15
J03/E03 $25
J04/E04 $40
P01/E01 $90 de depósito para el 100% de los cargos *
N01 Precio completo

* You may be requested to pay a negotiated price prior to services being rendered.
** Certain inpatient and outpatient procedures may be excluded from the discount program.

Pwosedi pou Pasyan ki Entèn ak Pasyan ki Pa Entène (dan ladan tou) **
(prè pou peye pa jou, aperè 3 jou)
J02/E02 $100 pa jou
J03/E03 $200 pa jou
J04/E04 $300 pa jou

Tès Laboratwa Woutin Ak Radyografi Woutin
J02/E02 $25
J03/E03 $50
J04/E04 $80
P01/E01 Depo $90 sou 100% frè pou peye a *
N01 Tout Pri a

Radyografi, MRI ki Chè
J02/E02 $40
J03/E03 $70
J04/E04 $100
P01/E01 Depo $200 sou 100% frè pou peye a *
N01 Tout Pri a

Reyabilitasyon, Terapi Enfizyon, Radyo-onkoloji
J02/E02 $15
J03/E03 $25
J04/E04 $40
P01/E01 Depo $90 sou 100% frè pou peye a *
N01 Tout Pri a

* Nou la mande ou pou peye yon pri negosye anvan nou ha ou sévis yo.
** Sëten pwosèdi pasyan ki enò ne ak pasyan ki pa entèn ak eskid nan pwogram rabè a.