Patient's Name:____

Street:____

City/State/Zip:____

SSN:____

TO WHOM IT MAY CONCERN:

I am experiencing financial hardship due to (check all that apply):

_____Job Loss   _____Health Problems ____Death in the Family ____Failed Business ______Reduced Income

I have not had a source of income for the past ______________________________. I contest that I do not have any type of bank account, savings account, IRA, inheritance or any other source of money and I have not filed taxes in the past year.

_____My friend(s)/family assist me in room and board,electric, water and/or food (or I get assistance from the State).

Name:____   Relationship____________________

Address:____

Telephone Number:____________________________

______I am currently homeless and live in a shelter from time to time.

______(Yes)______(No) I have filled out an application with Medicaid and do not qualify per their requirements.

I give permission for Florida Hospital Flagler to do a credit check on my behalf. I have provided my current address and phone number in case I need to be contacted.

Thank you,

Patient's Signature:____ Date:___________________

Witness:____

Form #9 – Hardship Letter   Revised October 2018