Coastal
Health Systems of Brevard
ALS, BLS, SCT

INDIGENT FINANCIAL FORM

RUN NUMBER: _____

PATIENT NAME: _____

Total annual income for last 12 months or previous year tax return:_____
This should include any SSI, disability, public assistance, child support, and current employment income received during this time.

TOTAL NUMBER OF DEPENDENTS LIVING IN HOUSEHOLD (as defined by IRS tax law)_____
This should include grandparents, children, and any person residing in your household.

MORTGAGE OR RENT PAYMENT_____

Please submit a copy of your previous year's income tax. If you have a caseworker and are receiving any type of public assistance, please have them fill out the appropriate income forms.

All information received will be subject to verification. All information obtained is and will remain confidential. This form is not valid without appropriate documentation.

SIGNATURE_____DATE_____

PRINTED NAME OF SIGNATURE_____

Revision Date 10/2010

486 Gus Hipp Boulevard
Rockledge, FL 32955
Visit us at: www.coastalhealth.org

Administration: *(321) 633-7050*
Communications: *(321) 631-1448*
Fax: *(321) 632-3005*