

**HALIFAX HEALTH – PATIENT ASSISTANCE**  
303 N. Clyde Morris Blvd., Daytona Beach, FL 32114  
(386) 425-4019

Patient Name  
Adm. Date  
Date of Birth  
MR #

Dr.  
Age

Visit #

## **VOLUSIA/FLAGLER HOMELESS COALITION APPLICATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex:  Male  Female

Current Monthly Income: \$ \_\_\_\_\_ Employer: \_\_\_\_\_

Please list any medications you currently take or require: \_\_\_\_\_

Please list any known health condition(s) you have (high blood pressure, diabetes, etc.): \_\_\_\_\_

### **STATEMENT OF FINAL CLEARANCE**

I, the undersigned, do hereby swear the information contained herein is true and correct. I hereby grant permission and authorize any bank, building association, insurance company, real estate company, financial institution, or credit grantor of any kind to disclose to any authorized agent of Halifax Health information of my past and present accounts and policies. I understand providing false information to defraud Halifax Health for the purpose of obtaining goods or services is a misdemeanor in the second degree in accordance with s. 817.50, Florida Statutes. I authorize this information be made available to all providers who participate in the Halifax Assistance program, should I be accepted. I agree to reimburse Halifax Health for the care and treatment in the event I recover any money for the injuries giving rise to the treatment. Any reimbursement shall be made at the rate found on the Halifax Health Charge Master at the time of service.

I understand that Halifax Health reserves the right to deny or suspend my eligibility under this program in the event that I am non-compliant, engage in any illegal activity pertinent to my care and/or act inappropriately to any agent of Halifax Health.

My care is related to an accident case which is pending litigation/settlement:  Yes  No

Attorney Name & Phone Number: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



HMC 95

# VOLUSIA/FLAGLER HOMELESS COALITION APPLICATION

## HEALTH SURVEY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

This Health Survey is to be completed on all new and renewal applications. The answers on this survey do NOT affect acceptance to the Halifax Health – Patient Assistance program.

Please list all physicians you have seen in the last 12 months and list the month and year of your last visit:

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Do you smoke?  No  Yes – How many packs per day? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_ years

Do you drink alcohol?  No  Yes – How many drinks per day? \_\_\_\_\_

What do you drink?  Beer  Liquor  Wine

Please list all hospitalizations or surgeries you have had (include month and year):

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Where were you born? \_\_\_\_\_

Are you a veteran of any U.S. Military Service?  No  Yes – Which branch? \_\_\_\_\_

Are you currently receiving any Social Security Benefits?  No  Yes – What is your monthly benefit amount? \_\_\_\_\_

Please list all medicines you take on a daily basis (include all herbs and over the counter medicine):

Name of Medicine:

How Often:

What for:

Name of Medicine:	How Often:	What for:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



**VOLUSIA/FLAGLER  
 HOMELESS COALITION  
 APPLICATION**

**HEALTH SURVEY (continued)**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever been diagnosed with any of the following conditions?

Medical Condition	Y / N	Date	What medicine do you take for this?	Comments
Degenerative Joint Disease – what joint(s)?				
Arthritis – where?				
Cellulitis (infection of the skin) – where?				
Hernia				
Thyroid Disease				
Stroke				
Osteomyelitis (infection in the bone)				
Hepatitis – Type and when diagnosed?				
Kidney disease – when diagnosed?				
High Blood Pressure				
Diabetes – what type?				
History of heart attack				
Emphysema or COPD				
Congestive Heart Failure				
Cancer – any type – please specify				

Your signature below means that the information provided is true and correct. False information can result in termination or limitation of Halifax Health – Patient Assistance (HHPA) benefits. Signing this form also indicates that you have received the sheet titled *Fast Facts* which outlines your responsibilities as an HHPA recipient and you agree to participate with the services offered.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

