JUPITER MEDICAL CENTER

Scholarship Application Form

To be considered for a Scholarship you **must provide** the following*:

A completed and signed Scholarship Application.

Proof of Income: (Please provide each of the following or an explanation of why not provided)

☐ Federal Income Tax return(s) for your household for the most recent calendar year.

☐ Bank Statements for all bank accounts for the last 2 months

☐ Two (2) most recent pay stubs or a statement from your employer regarding your income.

☐ ***If self-employed***, please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return.

☐ Unemployment statement showing denial or eligibility and amount receiving.

☐ Written documentation of **all** forms of income. *(i.e.trust funds, stock dividends, child support, alimony, social security, public assistance, food stamps, etc.)*

☐ If you have not had any income for the past three (3) months or there has been a recent change in your financial situation you **must** include a statement or letter explaining your situation. If someone else is supporting you, they must sign the support statement on page 4 of the application.

Identification:

☐ Two forms of identification (i.e. *driver's license, government issued photo ID, social security card, birth certificate or passport)*

Any other information that demonstrates financial hardship or need for financial assistance.
(i.e. public assistance award or denial letters, letters of support, bank statements, etc.)

** If, for any reason, you cannot provide us the information requested, please attach a written statement explaining why you cannot provide this information.*

Send completed applications and documentation to:

Jupiter Medical Center
Attn: Financial Counselor OR Fax 561-263-4124
1210 S. Old Dixie Hwy.
Jupiter, Florida 33458

Failure to submit all requested information may result in denial of your application. Applications should be returned prior to orientaion.

When applying for a scholarship you are giving consent for us to make necessary inquiries to confirm financial obligations or references. If you have any questions, **please contact our Financial Counselor at 561 263-3820**.

JUPITER MEDICAL CENTER

Scholarship Application

Information **Date: _____**

Name: _____ Date of Birth: _____ SS#: _____

Spouse or Guarantor Name: _____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____ Years/months at residence: _____

Home Phone:_____ Cell Phone:_____ Other Phone:_____

Household Information:

Member Name	Age	Relationship	Employer	Annual Gross Income
		Self		

Total Family Size: _____ Total Dependents: _____ Total Household Income: $_____

❖Scholarship amount you are requesting $_____

❖ If you have any other special circumstances which you would like us to consider when reviewing your application, please explain below:

_____
_____
_____
_____

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Financial Assessment

Monthly Expenses

Rent/Mortgage $_____
Utilities $_____
Food $_____
Cell Phone/Pager $_____
Cable $_____
Auto Loan $_____
Auto Insurance $_____
Loans $_____
Child Support $_____
Credit Card(Min Payment) $_____
Other $_____
$_____
$_____

Assets

Checking Account(s) $_____
Savings Account(s) $_____
Other Cash Assets $_____
Credit Cards (Available Credit) $_____

Monthly Gross Income

Employment Income $_____
Spouse Income $_____
Retirement Income $_____
Food Stamps $_____
Government Benefits $_____
Child Support $_____
Other $_____

Total Expenses $_____ Total Income $_____

TOTAL MONTHLY INCOME **$_____**

TOTAL MONTHLY EXPENSES **$_____**

AMOUNT AVAILABLE **$_____**

Patient/Guarantor Certification

I, _____, CERTIFY the information I have provided is true and accurate to the best of knowledge. I understand that if I do not cooperate with the hospital by supplying ANY additional requested information; my application may be denied for a scholarship. I understand that the information which I submit is subject to verification by the HOSPITAL, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I understand that this application pertains to the Mindfulness-Based Stress Reduction Program. I understand that if any information I have given proves to be untrue, the HOSPITAL will re-evaluate my financial status and take whatever action becomes appropriate

_____ _____
Patient/Guarantor Signature Date

For Office Use Only

Reviewed by:_____ Date: _____ Recommendation: ○ Charity _____% ○ Indigent ○ Denied: Reason _____	Approved by: _____ Date _____ _____ Date _____ _____ Date _____

JUPITER MEDICAL CENTER

Additional Financial Documentation
(Only completed when applicable)

Name_____ Date:_____

_____ **Support Statement:**

My signature will certify that I, _____, do provide all necessary essentials for living for the behalf of _____, and have done so for a period of _____ years / months.

_____ _____ _____
Signature of Patient's Supporter Relation to Patient Date

_____ **Homeless Affidavit**

I, (PRINT NAME) _____ hereby certify that I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

_____ _____
Signature Date

_____ **No Changes to Financial Status since Previous Application for Assistance**

I, (PRINT NAME) _____hereby certify there have been no changes to my (nor my spouse's) financial status since my previous application for a scholarship from Jupiter Medical Center which was completed on _____. Please select from the following options:

☐ I am still being supported by another. They do provide all necessary essentials for living for my behalf, and have done so for a period of _____ years/months.

☐ I am still Homeless. I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

☐ There are no changes to my (or my spouse's) income or household size since my previous application.

_____ _____
Signature Date

*Please complete this form in its entirety and email to MBSRSA@jupitermed.com