Route 3, Box 510
Callahan, Fl 32011

August 21, 1986

Nassau County Board
of County Commissioners
Callahan, Fl 32011

I, Rhonda R. Morris, agree to pay $20.00 per month to the Board of County Commissioners until total bill has been paid.

Rhonda Morris
Patient's Signature

Mary Sue Crawford
Witness

cc: Dr. N. G. Lund, M.D.
County Public Health Unit Director

Nassau County Board of County Commissioners

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

August 21, 1986

University Hospital of Jacksonville
855 W. 8th Street
Jacksonville, Fl 32209

Re: Rhonda Morris

To Whom It May Concern:

Rhonda Morris has been approved for County assistance for Dental Surgery scheduled August 22, 1986.

Please send your bill to us at Nassau County Health Department, P. O. Box 494, Fernandina Beach, Florida 32034.

Sincerely,

N. G. Lund, M.D.
County Public Health Unit Director

NGL/msc

NASSAU COUNTY HEALTH DEPARTMENT
DISTRICT FOUR P.O. BOX 494
4th & ASH STREET FERNANDINA BEACH, FLORIDA 32034
(904) 261-6191

BOB GRAHAM, GOVERNOR

Creasy Score:_____

NASSAU COUNTY HEALTH DEPARTMENT

C.M.I.P. FINANCIAL SURVEY

Name: Morris, Rhonda R. Birthdate: 12-05-63

Address: Rt. 3 Box 510 Callahan, Fl. Social Security No.: 267895410

Telephone No.: 879-2855 Number in Family: 1

Place of Employment (Each family member):	Gross Income (Each family member):
Divina Shops - Paxon Shopping Ctr. Jax.	Part-time $500 Mo (Wk)
	Mo/Wk
	Mo/Wk
	Mo/Wk

Was there period of unemployment in last six (6) months? Yes___ No___ How Long?_____

If yes, did you receive Workman's Comp./Unemployment? Yes___ No___ How Long?_____

OTHER INCOME:		OTHER EXPENSES:	
Social Security:	Rental Property:	Rent/Morg.:	$60.00/mo.
S.S.I.:	Other Investment Income:	Gas/Heat:	—
Unemployment:	Savings Account Amt.:	Electric:	—
Boarders:	Checking Account Amt.:	Telephone:	—
Pension:	Insurance Annuity:	Food:	—
Alimony:	Child Support:	Medicine:	
A.F.D.C.:	Food Stamp Amt.: No	Physician:	

TOTAL NET INCOME (All sources):_____

BENEFITS:

Medicare:_____ Medicaid:_____ Private Insurance:_____ (Company)

DEBTS: (Amounts)

Medical:_____ Hospital:_____ Drugs:_____

Other Unusual Expenses:_____

I certify that the above information is true to the best of my knowledge, That I am a resident of the State of Florida and of Nassau County and that I am not financially able to make payment for the requested services Physician $_____, Hospital $_____ Drugs $_____, Prenatal $_____.

Permission is granted the Nassau County Health Department to transfer all or parts of information obtained to other agencies concerning the health and welfare of the above named applicant. Consent is also given Clinic Management to verify proof of income and full-time residency.

SIGNED: Rhonda Morris 8-18-86 (Date) WITNESS: Jo Ann Swafford RN 8-18-86 (Date)

Drs: Jordan L. Schweitzer DDS 898 Rx: Dental C.M.I.P. Issued:_____

Dr. Anderson Dental Surg C.M.I.P. Denied:_____

_____ _____ Initialed By:

*Needs letter for loan from County for Dental Surg.

STATE LAW PROVIDES THAT CLIENTS WHO KNOWINGLY CONCEAL OR REPORT WRONG INFORMATION MAY BE SUBJECT TO PROSECUTION.

State can pay back loan @ $20.00/mo.

Revised: NCHD 11/84

UNIVERSITY HOSPITAL
OUT-PATIENT DEPARTMENT

15 August 1986

TO WHOM IT MAY CONCERN:

This is to verify that RHONDA MORRIS (is)(~~was~~)
name

being treated at UNIVERSITY HOSPITAL on 8/15/86
date

COMMENTS mult. non-restorable carious teeth # 1 and # 17
Non functional # 16 and 32. Conscious sedation
is indicated in this case for risk management

J Schweitzer DDS ~~M.D.~~
JORDAN L SCHWEITZER DDS 898
96280