Financial Assistance Application

Patients who are unable to pay for all or part of their health care services may apply for financial assistance by completing and returning this form. Patients who meet eligibility criteria may qualify for a reduction on his or her bill.

Please, visit www.caldwellmedical.com for a copy of our Financial Assistance policy and guidelines. Patients may also contact Caldwell Medical Center Business Office Monday – Friday 7:30am- 4:00pm at (270) 365-0331 to request a copy of this information.

Patients having any questions or needing assistance completing this application should contact:

Caldwell County Hospital, Inc. d.b.a. Caldwell Medical Center and Caldwell Medical Associates
Financial Counselor
Monday – Friday 7:30am – 4:00pm
(270) 365-0331

The following information and documents are required to process the Financial Assistance application:

- All fields must be completed on application form or marked as "N/A"
- Sources of income verification must be provided for household member over the age of 18, including:
  - 3 months of employment pay stubs
  - Tax return information for all family members in household
  - Proof of any income source listed on form
  - Approval/denial of eligibility for Medicaid or other state funded medical assistance
  - Approval/denial of eligibility for unemployment compensation
- Other information or supporting documents may be requested, i.e. power of attorney, guardianship documents, release of information, etc.

To submit this application, please bring application in person to Caldwell Medical Center Business Office Financial Counselor or mail to the following address:

Caldwell Medical Center Business Office
Attn: Financial Counselor
P.O. Box 410
Princeton, KY 42445

Caldwell Medical Center Financial Counselor will notify applicant of the final determination of eligibility within 14 business days of receiving a completed financial application.

Please complete all information, If it does not apply, write “N/A”.

Screening Information

Does the patient currently have insurance? Yes No
Has the patient applied for Medicaid? Yes No Date Applied:
Does the patient receive state public services such as WIC, food Stamps: Yes No
Is the patient currently homeless: Yes No
Is the Patient’s medical care need related to a car accident or work injury? Yes No
Has the patient applied and been denied for Disproportionate Share Hospital Program (DSH)?
Yes No
Are you a Kentucky resident: Yes No

Demographic information

Patient First Name	Patient Middle Name	Patient Last Name
Date of Birth	Social Security Number	Contact Information
		Home:
		Cell:
Mailing Address		
Patient First Name	Patient Middle Name	Patient Last Name
Date of Birth	Social Security Number	Contact Information
		Home:
		Cell:
Mailing Address		
Caldwell Medical Center Accounts		

If the applicant is not the patient, please complete the below section.

Guarantor Information

Guarantor Name	Relationship to Patient
Guarantor DOB	Guarantor SSN
Mailing Address	Contact Information: Home: Cell: Email:

Employment Information

Employment Status (responsible party)	Date of Hire:
____ Employed ____ Disabled	
____ Unemployed ____ Retired	Date of Unemployment:
____ Self Employer ____ Other	
Spouse Employment Status	Date of Hire:
____ Employed ____ Disabled	
____ Unemployed ____ Retired	Date of Unemployment:
____ Self Employer ____ Other	

List all family members in patient's household, including self. This includes individuals related by birth, marriage, or adoption who live in the home. All individuals over 18 must disclose income information. Income information includes the following sources: Wages, Social Security, Unemployment, Self-employment, Rental Income, Worker's Compensation, Disability, SSI, Child/spousal support, Work Study, Pension, Retirement account distributions, any other sources of income. W-2's will be required.

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Household Information

Name	Date Of Birth	Relationship to Patient	If 18 years or older: Employer(s) name or Source of income	If 18 years or older: Total gross monthly Income(before tax)

Income verification is required to determine financial assistance. Please, provide proof for every identified source of income.

Monthly Household income:

Income Information

Patient's Salary	$
Spouse's/Responsible Party Salary	$
Retirement/Pension	$
Social Security	$
Net Rental/Lease Cash Flow	$
Interest	$
Dividends	$
AFDC/TANF/Welfare	$
Child Support	$
Unemployment Benefits	$
Military Pay	$
Workmen's Comp Benefits	$
Other Income	$
Total:	$

Asset Information

Current checking account balance $_____	Savings account balance $_____

Does your family have other assets?

____Stocks ____410K ____Health Savings Account(s)

____Bonds ____Trust(s) ----Business ____Property (other than primary residence)

TOTAL $ _____

Additional Information

Please attach any additional documents or information regarding your current financial situation. This includes financial hardship and personal loss.

Financial Assistance Patient Agreement

I understand that Caldwell County Hospital, Inc., d.b.a. Caldwell Medical Center and Caldwell Medical Associates, may verify information by reviewing credit information and obtaining information from other sources to determine eligibility for assistance.

I understand by submitting this application, applicants consent Caldwell County Hospital, Inc., d.b.a. Caldwell Medical Center and Caldwell Medical Associates, representative to make necessary inquiries to confirm financial obligations and information submitted.

I agree that above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Witness Date