

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 <u>www.caldwellmedical.com</u> 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

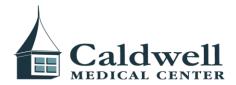
The following information and documents are required to process the Financial Assistance application:

- 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:
 - o 3 months of employment pay stubs
 - o 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
 - o 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 St	atus	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.



Household Information

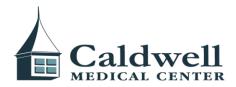
Name	Date Of Birth	Relationship to Patient	If 18 years or older: Employer(s) name or Source of income	If 18 years or older: Total gross monthly Income(before tax)

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?Stocks410KHealth Savings Ac	ccount(s)		
BondsTrust(s)BusinessP	roperty (other than primary residence)		
TOTAL \$			
Additional	Information		
Please attach any additional documents or infor situation. This includes financial hardship and p	· · · · · · · · · · · · · · · · ·		
Financial Assistance	Patient Agreement		
I understand that Caldwell County Hospital, Inc. Medical Associates, may verify information by re information from other sources to determine el	eviewing credit information and obtaining		
I understand by submitting this application, app d.b.a. Caldwell Medical Center and Caldwell Me necessary inquiries to confirm financial obligation	dical Associates, representative to make		
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.			
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Signature of Applicant	Date		
Signature of Witness	 Date		