Patient's Name: ______________________ Patient's Social Security # ______________________
Home Telephone Number: ______________ Cell Phone Number: ______________________

DSH ELIGIBILITY

Was date of service related to an auto accident? ______________

Income:

What is the household gross income for the past year? $______________

What is the household gross income for the past 3 months? $______________

What is the household gross income for the next 3 months? $______________

Estimate current monthly income: $______________

Resources:

Do you have any of the following? ☐Yes or ☐ No (If no please skip this section and move to Household members)

	Bank Name	Balance/Value
☐ Checking or Savings Account		
☐ Certificate Of Deposit		
☐ Money Market		
☐ Mutual Fund		
☐ Stocks		
☐ Bonds		
☐ Other		

Household members:

Name (First and Last)	Relationship	Age

Household Size	Resource Limit	100% of the Poverty Level	100% of the Poverty Level
1	$2,000	$1,041.00	$12,492.00
2	$4,000	$1,409.00	$16,908.00
3	$4,050	$1,778.00	$21,336.00
4	$4,100	$2,146.00	$25,752.00
5	$4,150	$2,514.00	$30,168.00

IF YOU HAVE NO INCOME PLEASE INITIAL HERE: ______________

****

MEDICAID ELIGIBILITY

1) Is the patient pregnant? ☐ Yes ☐ No
2) Is the patient disabled? ☐ Yes ☐ No (If yes, what is the date you filed your Disability Claim?______________)
3) Is the patient under the age of 18? ☐ Yes ☐ No
4) Is the patient a parent of minor children? ☐ Yes ☐ No
5) Is the patient a Kentucky Resident? ☐ Yes ☐ No

19. **Countable Resources:**

	Bank Name	Balance Value
a. Checking:		
b. Savings		
c. Money Market		
d, Mutual Fund		
e. Stocks		
f, Bonds		
g. Other		
* Total Health Bills Owed:		
*Total Resources:		

**Countable Resources shall be reduced by unpaid medical expenses of the family unit to establish eligibility.*

20. Other Information: a. Was date of service related to an auto accident? ☐Yes ☐No
b. Have you applied for and been denied Medicaid or KCHIP Benefits? ☐Yes ☐No

Section 2: Hospital Indigent Care Criteria

1. An individual must meet all of the following conditions:
   a. The individual is a resident of Kentucky
   b. The individual is **not eligible** for Medicaid or KCHIP
   c. The individual is **not** covered by a 3rd party payor
   d. The individual is **not** in the custody of a unit of government which is responsible for coverage of the acute care needs of the individual.

2. All income of a family unit is to be counted and a family unit includes:
   a. The individual;
   b. The Individual spouse who lives in the home;
   c. A parent or parents, of a minor child, who lives in the home;
   d. All minor children who live in the home.
3. Related and nonrelated household member(s) who do not fall into one of the groups listed above shall be considered a separate family unit.
4. Countable resources are limited to cash, checking and savings accounts, stocks, bonds, certificates of deposit, and money market accounts.
5. Countable resources may be reduced by unpaid medical expenses of the family unit to determine eligibility.

Section 3: Certifying Accuracy of Information

I hereby agree to furnish the Hospital all necessary information to allow them to determine my need to receive financial assistance for health care services received. I agree that the Hospital will be provided with or may obtain all documents necessary to verify my current income, employment status, and resources, and that failure to supply requested information within sixty (60) working days is grounds for denial of my application for assistance. I also agree to notify the Hospital immediately of any change of address, telephone number, employment status, or income.

I agree to allow the Hospital representative to determine eligibility and pursue state and federal assistance with Medicaid, KCHIP and DSH.

I certify that the information provided on this application is correct to the best of my knowledge and belief. I understand that if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I understand that I have a right to request a fair hearing if I am dissatisfied with any action taken on my application. I understand that I must contact the hospital to make a hearing request.

______________________________ __________
Individual or Responsible Party's Signature — Date

______________________________ __________
Hospital Employee Signature — Date

Does the individual appear to qualify for Medicaid? ☐Yes ☐ No
If yes, then refer the individual to benefind or to the DCBS office in the county of the individual's residence. The