St. Claire HealthCare

Financial Counseling
222 Medical Circle | Morehead, KY 40351
phone 606.783.6554 | fax 606.783.7687
www.st-claire.org

Financial Assistance Check List

Patient Name: _____

Account(s): _____

Date Information Requested: _____

Date Information Must Be Returned: _____

The following is required before we can process your financial assistance application at our facility. Your application will automatically be denied if this information is not received in the allotted time.

_____ Provide a copy of household's gross income verification for the past 3 months.

_____ Provide a copy of household's most recent income tax return

_____ Provide a copy of your benefits award letter that indicates household member's monthly social security benefit amount.

OR

_____ Provide the zero income form given to you only if there has been no income in the household for the past three months. The form MUST be filled out by two people living outside of your household.

AND

_____ Provide a copy of household's last three months bank statements, all pages.

_____ ATM receipt from Direct Express card for social security amount.

_____ Provide a Medicaid spend down or KCHIP inquiry letter from your local community based services office.

_____ Complete all areas on the application.

If you should have any questions, please call our financial counseling office.

Phone: 606-783-6554, 606-783-6320, 606-783-6454, 606-783-6452.

Fax: 606-783-7687.

Email: financialcounseling@st-claire.org