Financial Assistance Application

Patient Name: _____ Application Date: _____

Thank you for contacting us regarding financial assistance on your account balance(s). In order to process your application, we request that the following information be returned with your signed, completed application within 7 business days. If you have any questions or need additional forms, please visit our office or contact us at 270-651-4752. Applications can be returned in person or mailed to:

Attn: Claim Aid/Financial Assistance
TJ Regional Health
1301 N Race Street
Glasgow, KY 42141-3454

Current Proof of Income for All Members of the Household

	Proof of income (Full month of check stubs w/ YTD gross earnings)
	Verification of Non-Income Form if not currently working
	Copy of Social Security Retirement, Social Security Disability, or SSI Award Letter
	Any additional income (Alimony, Unemployment, Food Stamps, etc.)

Bank Account

	Copy of all pages of most recent bank statement(s) – Checking and Savings (if applicable)
	Verification of Non-Bank Account form if no checking or savings accounts exist

Taxes

	Copy of 1040 page of most recent income taxes (If any deductions, please included the applicable Schedule C, Schedule F, etc.)

Expenses

	Proof of Rent/Mortgage (Loan Statement, Copy of Bill, Rent/Lease Agreement, Signed Statement From Landlord, or Receipt)
	Copy of most recent utility bills (Electric, Water, Garbage, and/or Gas Heat)
	Pharmacy Statement for monthly prescriptions
	Any other medical/pharmacy bills for any other facilities/entities
	Proof of Health Insurance and Car Insurance Payments
	Proof of Daycare Expenses (Receipt or Signed Statement From Facility)

MRN#_____ Approved_____ Denied_____ Did not return Info_____

Patient Name:_____ Date of Birth:_____ SSN: _____ Application Date: _____

Address: _____Phone: _____Marital Status: ___

Spouse/Parent Name: _____Spouse/Parent Date of Birth: _____Spouse/Parent SSN:_____

Primary Insurance: _____ID# _____Insured Person: _____

Accident/Crime? _____ Someone else responsible? _____Have you recently applied for Disability? Y or N
If yes, what is your filing date: _____ & status? Pending: ( ) Hearing ( ) Reconsideration( ) Judge's decision:
Attorney's Name? _____

Have you received an Eligibility Review for Medicaid by the local Family Service Office? Y or N If yes, please provide copy of Letter. If no, refer to Family Service.

Contact name/telephone number of a person not living with you: _____

Household Member's Name	Relationship	SSN	Age

Add additional Household members on back of page. Number of people in the household (including patient) _____

EMPLOYMENT:
Patient/Parent 1 Employer: _____ Length of Employment or Hire Date: _____

Spouse/Parent 2 Employer: _____ Spouse Length of Employment or Hire Date: _____

GROSS INCOME:
Patient/Parent 1 gross wages from paychecks/W2's ……_____

Any other household gross wages from paychecks/W2's …… _____

Social Security/SSI/Disability/K-Tap: ……. _____

Pension ……..…… _____

Food Stamps: ……_____

Other Income (Ex: Alimony, Unemployment) ……_____

TOTAL MONTHLY INCOME…… _____

EXPENSES:
Rent/Mortgage: ……..____

Utilities: ……..____

Medical Expenses: ……..____

Prescribed Meds: …… ____

Health &Auto Insurance: …….____

Other Expenses (Ex: DayCare)……..____

TOTAL MONTHLY EXPENSES.....____

RESOURCES:
Checking and Savings Accounts: …… $ _____

Stocks and Bonds Value: …….. $ _____

Other resources? Yes or No; If yes, list: _____

Real Estate other than primary residence:

Value: $_____ Balance Owed: $_____

TOTAL RESOURCES: **…….. _____**

I certify that the information provided in this application is correct and true to the best of my knowledge and belief. I understand that if I give false information or withhold information in applying for assistance, my application may be denied and TJ Regional Health may pursue collection of any outstanding balance due. In that instance, I may also be subject to prosecution for fraud. I agree to notify TJ of any changes to the information provided in this form including address, telephone number, and income.

_____ _____
(Patient/Parent 1 Signature) (Date)

_____ _____
(Spouse/Parent 2 Signature) (Date)

Discount % Approved _____

FC Signature & Date _____

Approval Signature & Date_____