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 270-659-5875. Applications can be returned in person or mailed to:

Attn: 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
	Any additional income (Alimony, Unemployment, Food Stamps, etc.)

Bank Account

	Copy of all pages of 3 most recent bank statement(s) – Checking, 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.)

T.J. Regional HEALTH

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.

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: _____ Length of Employment or Hire Date: _____

GROSS INCOME:		**CASH AND INVESTMENTS:**	
Patient/Parent 1 gross wages from paychecks/W2's……..		Checking Account(s) ……	
Any other household gross wages from paychecks/W2's		Savings Account(s)……	
Social Security/SSI/Disability/K-Tap……		Stocks and Bonds Value……	
Pension……		Other resources? Yes or No	
Food Stamps……..……		If yes, list:	
Other Income (Ex: Rental, Alimony, Unemployment)…		_____	
TOTAL ANNUAL INCOME	$_____	**TOTAL ASSETS**:	$_____
TOTAL FAMILY RESOURCES FOR CHARITY DETERMINATION:			$_____

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:_____