FINANCIAL ASSISTANCE APPLICATION

For your application to be processed, you must provide:

- Information about your family
  - Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Information about your family's gross monthly income (income before taxes and deductions)
- Declare assets (as listed on financial assistance application form)
- Attach additional information if needed
- Sign and date financial assistance form

*****Income Source Verification Required*****

Please submit copies of the following documents with your application:

1. Last 2(most recent) pay stubs
2. Recent filed federal tax return for all family members. If self-employed, please include entire tax return, including all schedules.
3. If unemployed, provide proof of unemployment benefits, work comp benefits, Social Security/retirement benefits, government assistance (Food Stamps, General Relief, WIC, etc.), child support, disability benefits, or letter of signed support
4. Proof of any other income source as listed on financial assistance application form

You do not have to provide a Social Security number to apply for financial assistance. However, if you provide us with your Social Security number, it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail completed application with all documentation to (be sure to keep a copy for yourself):

ULH Business Office

PO Box 457

Louisville, KY. 40201

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 20 calendar days of receiving a complete financial assistance application, including documentation of income. By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

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Patient Information

Name:

Date of birth:	SSN:	Phone:

Current address: Rent ☐ Own ☐

City:	State:	ZIP Code:

Name Person Responsible for Paying Bill (Guarantor)

Relationship to Pt	Date of Birth	SSN

Marital Status (circle one): Married Single Separated Divorced Widowed

Employment status of person paying bill: (circle all that apply)

Employed Date of Hire________________________ Unemployed (How Long)________________

Student Disabled Retired Other__________________________________

List family members in your household, including you. “Family” includes people related by birth, marriage, or adoption who live together.

TOTAL FAMILY SIZE_________________

TOTAL FAMILY SIZE

Name	Date of Birth	Relationship to Pt	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also Applying for Assistance?
					Y/N
					Y/N
					Y/N
					Y/N

All adult family members' income must be disclosed. Sources of income include, for example: - Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support - Work study programs (students) - Pension - Retirement account distributions Family/Friend Support - Other(please explain_____________) **Verification of all income must be provided, including a letter of support if you do not have any income**

Monthly Expenses

Rent/Mortgage $	Medical Expense $	Insurance $
Utilities $	Auto $	Other $

Assets

Checking Acct Balance $	Savings Acct Balance$	Other $

Circle all that apply to any household member: 401K Stocks Bonds Health Insurance Savings Account
Trusts Property Own a Business Other____

Have you applied for Medicaid or any other state/county assistance? (circle one) Yes / No. If yes, please provide the following:
Application Date: Status of Application: Caseworker's Name: Caseworker's Phone #:

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, seasonal or temporary income, or personal loss.

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* I certify that the information I have provided is true and accurate to the best of my knowledge.

* I will independently or with the assistance of hospital personnel apply for ANY and ALL Assistance which may be available through federal, state, local government and private sources to help pay this healthcare bill.

* I understand that if I do not cooperate with my healthcare provider in providing requested information, my application may be denied for possible financial assistance.

* I understand that the information which I submit is subject to verification by my healthcare provider, including credit reporting agencies and subject to review by Federal and/or State agencies and others as required.

* I understand that additional information may be requested in order to qualify for assistance.

Patient Name (Print)	Date:
Signature of applicant	Date