Ephraim McDowell Health

Exhibit B
Financial Assistance Application and Instructions

1. If you are **uninsured** a Medicaid denial letter needs to be obtained before an application can be reviewed.
2. Complete the Financial Assistance application
3. Include all monthly income in the spaces provided.
4. Provide proof of income, including:
    a) Last 2 pay stubs OR most recent filed W-2;
    b) Most recent tax returns, showing dependents as well (form 1040)
    c) Most recent bank statements
    d) Benefit awards letters or 1099 forms or bank statements showing Social Security, Disability, Worker's Compensation, or Veteran's Administration benefits;
    e) Copies of benefit award letters or 1099 forms showing Unemployment, Retirement*, or Pension benefits;
    f) Proof of Assets which may include, but not limited to checking, savings, investments, holdings, and retirement accounts for most recent three months. Any amount of total assets that exceed $10,000 will be counted as income (ex: Total assets equal $15,000 then $5,000 will be counted in total income);
    g) Verification of self-employment status and income received:
        (1) Receipts from clients,
        (2) Signed Federal income taxes from the most recent filing year which include the appropriate schedule showing income from self-employment, S-corp, or other such entity.
5. Sign the financial assistance application.
6. If you have no income, you will need to provide an explanation of how you meet your daily living expenses.

*If you have questions or need assistance completing this application, please call (859) 239-2333. Or visit a Financial Counselor located at 217 South Third Street, Danville, KY 40422, Monday through Friday, 7:00am to 4:30pm, Fort Logan Hospital Monday – Tuesday 8:30 am to 5:00 pm, and at James B. Haggin Hospital Wednesday through Friday 8:30 am to 5:00 pm.

Mail the completed application and documents to:
Ephraim McDowell Health, Inc.
217 South Third Street
Danville, KY 40422
ATTN: Financial Counselor

Once we have received all of the information and documentation requested, we will make a determination and notify you by mail of your eligibility for participation in the Financial Assistance Program within 30 days.

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Ephraim McDowell Health

Responsible Party Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Phone: _____

_____ Marital Status: _____

Spouse Name: _____ Spouse Date of Birth: _____ Spouse SSN: _____

Are you insured? : YES NO Insurance Carrier: _____

Household Member's Name	**Relationship**	**SSN**	**Date of Birth**

(Use back of page for additional Household Members) Number of people in the household (including patient) _____

Employment:
Employer: _____ Length of Employment or Hire Date: _____
Spouse Employer: _____ Spouse Length of Employment or Hire Date: _____

GROSS INCOME:	Monthly ($)
Responsible party or patient's gross wages from paychecks/W2s…….	_____
Spouse's and any children's gross wages from paychecks/W2s……	_____
Alimony……..	_____
Social Security……	_____
SSI/Disability/K-Tap……..	_____
Unemployment……	_____
Pension……	_____
Rental Property Income……	_____
Child Support (only if child is applying)…….	_____
Other Income (e.g., Investment, Workers' Comp.): Yes/No (circle one) If yes, list: _____	_____
Total Monthly Income…….. $	_____

Resources:	
Checking and Savings Accounts……..	_____
Stocks and Bond Values……...	_____
Real Estate other than primary residence: Value _____ Balance Owed _____	
Other resources? Yes/No (circle one) If yes, list: _____	_____
Total Resources…….	$ _____

I certify that the information provided by me 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 Ephraim McDowell 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 EMH of any changes to the information provided in this form including address,

Telephone number, and income.

_____ _____
(Responsible Party Signature **(Date)**

_____ _____
(Spouse Signature) **(Date)**

OFFICE USE ONLY
Discount % Approved _____
Date Submitted _____
FC Signature _____
Approval Signature_____
Date Approved _____

Not Part of Medical Record

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Ephraim McDowell Health

Statement of Income

I understand that intentionally falsifying information regarding my household size and/or income will result in denial. I will be liable for charges of services provided.

If you have no income, you will need to provide an explanation of how you meet your daily living expenses.

Household size _____

Total household income $_____ (monthly)

Statement of No Income (fill out only if there is no source of income**)**

_____ has ZERO earned income since _____
Patient Name Date

I certify that the above referenced information is correct to the best of my knowledge.

Signature _____ Date _____

Relationship to Patient _____

Not Part of Medical Record

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