

EXHIBIT B**FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS**

1. If you are **uninsured** a Medicaid application must be filed and a coverage 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 only proof of income that applies to you, including (not all may apply):
 - a) Last 2 pay stubs OR most recent filed W-2 for all adult household members;
 - b) Most recent tax returns, showing dependents (form 1040)
 - (1) If no tax return is available, proof of dependency is required (ex: birth certificate)
 - c) Most recent bank statements (including savings accounts)
 - d) Benefit awards letters or 1099 forms showing Social Security, Disability, Worker's Compensation, or Veterans 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 (if receiving monthly dividends) 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. A signed letter from a non-household individual must be included to confirm you have no income.

*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 8:00 am to 4:30 pm, and at James B. Haggin Hospital Wednesday through Friday 8:00 am to 4:30 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.

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:

Responsible party or patient's gross wages from paychecks/W2s..... Monthly (\$) _____

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, Worker's Comp, etc.): Yes/No (circle one) If yes, list: _____

Total Monthly Income..... \$ _____

RESOURCES:

Checking and Savings Accounts..... _____

Stocks and Bonds Values..... _____

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 subjected 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 _____

STATEMENT OF NO INCOME (fill out only if there is no source of income)

If you have no income, you will need to provide an explanation of how you meet your daily living expenses. An individual who is not part of your household will need to provide a letter on your behalf, confirming you receive no income and sign this statement of certification.

_____ has had 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 _____