HIGHLANDS HEALTH SYSTEM

FINANCIAL ASSISTANCE APPLICATION

APPLICANT INFORMATION		
Patient Name:		
Date of birth:	SSN:	Phone:
If patient is a minor, Parent's Name:		
Marital Status S M D W (Please circle) Spouse's Name:		Pregnant: Y N **(Please circle)**
Current address:		
Own Rent (Please circle)	Rent or Mortgage payment: $	Live here since?
Landlord or Mortgage Holder:		
Address	City/State/Zip:	Phone #:

EMPLOYMENT INFORMATION (PATIENT OR PARENT/GUARANTOR)		
Current employer:		Date employed:
Employer address:		Phone:
Position:	Hourly or Salary **(Please circle one)**	Annual income:
Previous employer:		Date employed:
Employer address:		Phone:
Position:	Hourly or Salary **(Please circle one)**	Annual income:

EMPLOYMENT INFORMATION (SPOUSE OR OTHER EMPLOYED INDIVIDUAL IN HOUSEHOLD)		
Current employer:		Date employed:
Employer address:		Phone:
Position:	Hourly or Salary **(Please circle one)**	Annual income:
Previous employer:		Date employed:
Employer address:		Phone:
Position:	Hourly or Salary **(Please circle one)**	Annual income:

LIVING IN HOUSEHOLD				
Name	**Relationship**	**Age**	**Income Source**	**Monthly Income**
			TOTAL	

Current Insurance Coverage	Policy / Group Number
Medicare	
Medicaid	
Other:	

FINANCIAL ASSISTANCE APPLICATION

BANKING - CHECKING / SAVINGS / INVESTMENTS ACCOUNTS			
Type	**Bank**	**Account No.**	**Balance**
Checking Account			
Checking Account			
Checking Account			
Saving Account			
Saving Account			
Certificates of Deposit			
Money Market			
Mutual Funds			
Stocks and/or Bonds		.	
Other			

OTHER ASSETS OR SOURCES OF INCOME			
Type	**Description**	**Value**	**Balance**
Primary Vehicle			
Secondary Vehicle			
Non-homestead Property			
Burial Reserves			

As provided for in Federal Law, I hereby request that Highlands Health System make a written determination of my eligibility for charity assistance at Highlands Regional Medical Center (HRMC). I understand that the information concerning my income and family size is subject to verification by HRMC. I also understand that if the information I submit is determined to be false, such a determination will result in a denial of my application for charity assistance and that I will be liable for charges for services provided. I authorize Highlands Health System to verify the information provided on this form as to my credit and employment history.

I affirm that all the information listed in this application is true to the best of my knowledge and belief.

Signature of applicant	Date:
Witness:	Date:

I have been informed that I may qualify for Medicaid or KCHIP coverage. I have decided not to apply for Medicaid or KCHIP coverage and understand that this refusal may result in me being billed for any services rendered by Highlands Health System.

Signature of applicant	Date
Witness:	Date

Application was reviewed by:_____Date:_____

____ Approved ____% of Charity Approved for service till: _____

____Denied Reason for denial: _____

Highlands Regional Medical Center
Financial Assistance Guidelines 2017

2017 Federal Poverty Guidelines Discount 100%		GROUP I Discount 90% 101% - 138% PL	GROUP II Discount 80% 139% - 150% PL	GROUP III Discount 60% 151% - 175% PL	GROUP IV Discount 50% 176% - 200% PL
Family S	Guidelines	From - To	From - To	From - To	From - To
1	$ 12,060	$ 12,061 - $ 16,643	$ 16,644 - $ 18,090	$ 18,091 - $ 21,105	$ 21,106 - $ 24,120
2	$ 16,240	$ 16,241 - $ 22,411	$ 22,412 - $ 24,360	$ 24,361 - $ 28,420	$ 28,421 - $ 32,480
3	$ 20,420	$ 20,421 - $ 28,180	$ 28,181 - $ 30,630	$ 30,631 - $ 35,735	$ 35,736 - $ 40,840
4	$ 24,600	$ 24,601 - $ 33,948	$ 33,949 - $ 36,900	$ 36,901 - $ 43,050	$ 43,051 - $ 49,200
5	$ 28,780	$ 28,781 - $ 39,716	$ 39,717 - $ 43,170	$ 43,171 - $ 50,365	$ 50,366 - $ 50,000
6	$ 32,960	$ 32,961 - $ 45,485	$ 45,486 - $ 48,000	$ 48,001 - $ 50,000	$ 50,001 - $ 53,000
7	$ 37,140	$ 37,141 - $ 51,253	$ 51,254 - $ 51,000	$ 51,001 - $ 53,000	$ 53,001 - $ 56,000
8	$ 41,320	$ 41,321 - $ 57,022	$ 57,023 - $ 56,000	$ 56,001 - $ 57,000	$ 57,001 - $ 58,000

#

* Federal Register Notice January 22, 2015
* $4,160 for each additional family member

**** Maximum Income Guideline is $58,000 unless severe hardship can be verified***

****Patients must be denied for Presumptive Medicaid/Medicaid prior to being considered for financial assistance.***

****All patients will be reviewed on an individual basis.***

**Financial assistance will not be available for accounts that have been denied by insurance due to medically necessary.*

**Financial assistance will not be available for automobile accidents or worker compensation unpaid balances.*

Financial Assessment

Patient _____ FIN _____

Monthly Expenses		
Expense Type	**Amount**	**Comment**
Home Mortgage/Rent		
Home Insurance		
Electricity		
Utilities (water, garbage, etc)		
Groceries (In addition to food stamps)		
Phone (house or cell)		
Installment Payment: Primary Vehicle		
Car Insurance		
Hospital Bill: Specify Hospital		
Hospital Bill: Specify Hospital		
Doctor Bill: (Specify Provider)		
Doctor Bill: (Specify Provider)		
Doctor Bill: (Specify Provider)		
Doctor Bill: (Specify Provider)		
Doctor Bill: (Specify Provider)		
Doctor Bill: (Specify Provider)		
Prescriptions (your costs)		
Health Insurance Premium		
Life Insurance Premium		
TOTAL EXPENSES		

COPIES OF BILLS ARE NOT REQUIRED AT THE TIME OF APPLICATION. WE MAY REQUEST COPIES OF MEDICAL BILLS IF IT IS DETERMINED THAT YOU EXCEED THE MAXIMUM RESOURCE AMOUNT.

HIGHLANDS REGIONAL

As you requested, enclosed is an application for financial assistance for your services at Highlands Regional Medical Center. Please return this completed application as soon as possible, along with all other necessary documentation. If you have any questions, please do not hesitate to call our office.

Thank you,

Cecelia Russell - Patient Access Supervisor

- Proof of Income-All Sources. (Last 3 months check stubs, Social Security benefit letter, etc.)
- Food Stamp Letter- if applicable.
- Expense Summary-Listing of all bills paid monthly (it is not necessary to attach copies).
- College Schedule-For children 18+ living in the home who are enrolled full time.
- No Income Verification-If 0 income, have a non-relative write and sign a statement to verify.
- Bill Pay Verification-If 0 income, have person who pays bills or gives money write and sign a statement to verify.
- Separation Verification-If separated from spouse and not living in the same home, have non-relative write and sign a statement to verify.
- Current Bank Statement for Past 90 days - All Accounts (including stocks, bonds, mutual funds, and certificate of deposit).

You may fax, mail, or stop by with your information.

Highlands Regional Medical Center

Attn: Cecelia Russell

PO Box 668

Prestonsburg, KY 41653

Phone (606) 886-7413 Fax (606) 886-7509