Ohio County Hospital
1211 Main Street
Hartford, KY 42347

Financial Assistance Application

Thank you for choosing Ohio County Hospital for your healthcare needs.

We are pleased to provide you with this application to determine if you meet the qualifications for assistance with your medical expenses. In order for us to process your application, the information requested must be completed in its entirety. Please be assured information you provide will be treated as confidential and will only be used to determine whether financial assistance can be provided to you.

As part of the review processed, we ask that you submit all the applicable documentation listed below. All pages of all documents are required and no altered documents will be accepted. If Federal income tax guidelines require you to complete a tax return, that return must be completed before financial assistance can be considered. Failure to provide all requested information may cause your application to be denied. Falsification of any kind may result in permanent denial for financial assistance under the FAP policy for Ohio County Hospital Corporation. You must exhaust all forms of state assistance before qualifying for assistance. The required documents are as follows:

- ☐ Fully completed and signed Financial Assistance Application
- ☐ Copy of your most recent Federal tax return, including W-2's and all schedules.
- ☐ Copies of the two (2) most recent pay stubs for all wage-earners in the household
- ☐ Proof of Social Security, disability, pensions, and any other forms of income for all household members
- ☐ Evidence of letter showing Medicaid application or lack of eligibility (full cooperation with our staff or Financial Counseling Office will be acceptable evidence)
- ☐ Proof of family size if not listed on tax document

For assistance in completing application, contact the Patient Financial Counseling Office at 270-298-5431 or 270-298-5138, Monday through Friday, 8:00am to 4:00pm, or visit the financial counseling office.

FOR HOSPITAL USE ONLY

Application Accepted by: _____ Date: _____

APPROVED: _____ REJECTED: _____ INCOMPLETE: _____ INDIGENT CARE: _____

Approved By: _____ Date: _____

Application must be approved by Director of Patient Financial Services or Authorized Personnel

Ohio County Hospital
1211 Main Street
Hartford, KY 42347
Attention: Patient Financial Counseling Office

Financial Assistance Application

Ohio County Hospital Corporation offers a financial assistance program for patients in financial need. Patients that do not qualify for assistance through Medicaid may qualify for charity care based on the Federal Poverty Guidelines. Please answer all questions completely and to the best of your knowledge in order to prevent delaying this application. Copies of income from all sources and required tax documentation MUST be attached or application will be rejected as incomplete.
( ) Financial Assistance – Ohio County Hospital services
( ) Financial Assistance – Ohio County Hospital clinic services

Today's Date: _____

Patient's Name (Please Print): _____

Patient Date of Birth: _____ Phone Number: _____

Applicant Name (if someone other than patient): _____

Street Address: _____
City: _____ State: _____ Zip Code: _____

- What state did you reside in at the time of service? _____
- Were you an active Medicaid recipient at the time of service? Yes _____ No _____
  If yes, Medicaid recipient ID number: _____
- Did you have health/liability insurance (other than Medicaid) at the time of service? Yes _____ No _____
  If yes, enter Subscriber name and ID number: _____

Please list all "family" members (including yourself). Family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parents (regardless of where they reside), and the parent's children under 18 (natural or adoptive) who live in the patient's home.

Name	Age	Date of Birth	Relationship to patient	Gross Income 3 Months Prior to Date of Service	Source of Income or Employer

Note: If no income is reported for the above time period, please mark "none" as the income source and place $0.00 as the income.

By signing this application, you are acknowledging that this is an application for financial assistance under the FAP policy for Ohio County Hospital Corporation and you agree that any and all information provided in this application is accurate to the best of your knowledge.

_____

Applicant's Signature Date