Dear  Patient,

St. Elizabeth Healthcare understands that hospital medical care can create unexpected financial hardships for patients and their families.  We offer several financial assistance programs designed to help relieve this burden.

We have enclosed a financial assistance application.  In order for the application to be processed all questions must be answered, if non-applicable mark 'NA'. Please complete and sign the application. You must also include household expenses as well as any other income. **If any portion is missing or proof of income is not included, we will be unable to process your application.**

In order to check for program eligibility we require verification of all household income for the twelve months prior to your date of service. Please attach copies of the following that would prove household income:

- Most recent Pay Stub
- Tax returns (Prior Year, or year(s) applying for)
- Social Security Awards letter **and bank statement (showing Social Security Direct Deposit)**

Also please note that while your application is under review, you will continue to receive statements.

If you have additional questions or need assistance in completing the application please call 859-655-1925, Monday through Friday from 8:00am-3:00pm to speak with a Financial Assistance Program Representative, or email us at financialassistance@stelizabeth.com.  If you are calling after business hours, please leave your contact information and a brief message and we will return your call within 1 business day.

Please allow up to 30 days for your application to be reviewed. Thank you for choosing St. Elizabeth Healthcare for all your healthcare needs.

Sincerely,

Patient Financial Services

1 Medical Village Drive • Edgewood, KY 41017

**ADDRESSEE:**

**RETURN APPLICATION TO:**

ST. ELIZABETH HEALTHCARE
ATTN:  FINANCIAL ASSISTANCE APPLICATION
1 MEDICAL VILLAGE DRIVE
EDGEWOOD KY 41017

DATES OF SERVICE: _____ _____ _____ _____

PATIENT ACCOUNT: _____ _____ _____ _____

PATIENT NAME: _____ SPOUSE OR PARENT NAME _____

SOCIAL SECURITY _____ DATE OF BIRTH _____

_____ ADDRESS _____ CITY

_____ STATE ZIP _____ PHONE (_____)

_____ CELL( ) _____

EMPLOYER _____ IF UNEMPLOYED, LAST DATE EMPLOYED _____

| DEPENDENT'S NAME | SOCIAL SECURITY # | DEPENDENT'S NAME | SOCIAL SECURITY # |
|---|---|---|---|
| _____ | - _____ | _____ | - _____ |
| _____ | - _____ | _____ | - _____ |
| _____ | - _____ | _____ | - _____ |

FAMILY INCOME (Gross Income before Taxes - Most Recent 12-Month Period)

| **Patient** | | **Spouse** | |
|---|---|---|---|
| Salary/Wage/Tips: | $_____ | Salary/Wages/Tips: | $ |
| Interest/Dividends: | $_____ | Interest/Dividends: | $_____ |
| Alimony: | $_____ | Alimony: | $ |
| Social Security: | $_____ | *Social Security: | $_____ |
| Pension/Retirement: | $_____ | *Pension/Retirement: | $ |
| Disability: | $_____ | Disability: | $_____ |
| Unemployment: | $_____ | Unemployment: | $_____ |
| Workers Comp: | $_____ | Workers Comp: | $_____ |
| Self Employed: | $_____ | Self Employed: | $_____ |

**Total Annual Household Income$_____ Average Monthly Household Income$_____**

(Please fill out completely, if does not apply please place a 0 on the line.)

**Family Resources/Assets**

Checking Account Balance $_____ Name of Bank _____

Savings Account balance $_____ Name of Bank _____

IRA/401K/403B_____ Name of Bank _____

**PROPERTY VALUE (House or personal property other than your residence)**

Description/Location_____ Market Value: $_____

## Monthly Expenses

| | |
|---|---|
| Housing | $ |
| Automobile | $ |
| Insurance | $ |
| Utilities (gas, electric, water) | $ |
| Health Insurance | $ |
| Medical | $ |
| Fuel | $ |
| House Hold Expenses | $ |
| Credit Cards | $ |
| Cell Phone | $ |
| Home Phone | $ |
| Cable | $ |
| Other (be specific) | $ |
| Other (be specific) | $ |
| Other (be specific) | $ |
| Other (be specific) | $ |
| **Total Monthly Expenses** | $ |

**Average Monthly Income from Page 1 $_____ Total Monthly Expenses Listed above $ _____**

*I certify that the information provided by me in this application is correct and true to the best of my knowledge. I understand that if I give false information or withhold information, assistance may be denied or reversed at the discretion of St. Elizabeth Healthcare.*

**Patient Signature:**_____ **Date:** _____

**Spouse Signature:**_____ **Date:** _____

**.....This Space is for Hospital Personnel.....**

Application Reviewed By:_____ Date Reviewed _____