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(S) ________________ ____________________ ___________________ ______________________

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/Wages/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 enter 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 ______________________