



Thank you for choosing UK HealthCare for your healthcare needs.

UK HealthCare is proud of its long history of providing healthcare services to the Commonwealth of Kentucky. Our financial assistance program relieves the financial burden of medically necessary health care. It is available to patients and families with a household income at or below 300% of the Federal Poverty Guideline for your family size. We are pleased to provide you with this application to determine if you meet the qualifications for assistance with your medical services at UK HealthCare.

We require you to complete the enclosed application and provide all required supporting documents to determine your eligibility. All pages of the supporting documents must have the applicant's name and date of birth on the top of each document. If the patient's medical record number is available, include that information along with the name and date of birth. Return the signed, the completed application and the supporting documents via USPS upload through My UKHC Chart at <https://ukhealthcare.uky.edu/mychart>, or submit by secure fax to 859-257-8071. **Failure to return a completed application within 21 days of the application date with all supporting documentation, including name and date of birth on each document may delay a decision or result in a denial of the application.** Note: Applicants who are eligible for Medicaid, must apply before we can consider the request for financial assistance. During the application process, all normal billing operations will continue.

**Disclaimer for Financial Assistance**

**Approval of financial assistance does not guarantee coverage for all services; all services are subject to the terms, conditions, limitations, and exclusions of the financial assistance policy. If approved, adjustments will only be applied to those accounts within the policy parameters.**

**Required Documents**

- Completed and signed Financial Assistance Application
- Proof of gross income and bank account balances for each member of the household OR proof of no income. Gross income is the income before taxes, insurance, and any other deductions.

Please do not send the original documents, as we may be unable to return them. All financial records after electronic imaging in our secure electronic health system and any unidentifiable required documentation are destroyed. We make every effort to identify each document we receive. To avoid destroying your documentation without attaching it to your application, record the patient's identifiable information on each documentation sheet by putting the patient's name and date of birth. If you have questions or need assistance, call our convenient call line at 859-323-9898 Monday-Friday, 8 AM-4:30 PM. Thank you for choosing UK HealthCare for your medical needs.

2024 Federal Poverty Guidelines				
Financial support depends of where the household income falls within this chart. Please call or contact us through MyChart for screening eligibility.				
	Medicaid Limit for Adults Traditional Medicaid	Expanded Medical Limit For Adults	Medicaid Limit for Children & Pregnancy	UK Financial Assistance Program
Household Size	0%-100% FPL	101%-138% FPL	Up to 200% FPL	Up to 300% FPL
1	\$15,060.00	\$20,783.00	\$30,120.00	\$45,180.00
2	\$20,440.00	\$28,207.00	\$40,880.00	\$61,320.00
3	\$25,820.00	\$35,632.00	\$51,640.00	\$77,460.00
4	\$31,200.00	\$43,056.00	\$62,400.00	\$93,600.00
5	\$36,580.00	\$50,480.00	\$73,160.00	\$109,740.00
6	\$41,960.00	\$57,905.00	\$83,920.00	\$125,880.00
7	\$47,340.00	\$65,329.00	\$94,680.00	\$142,020.00
8	\$52,720.00	\$72,754.00	\$105,440.00	\$158,160.00



**UKHC Financial Assistance Application**

Medical Record # if known \_\_\_\_\_

**INSTRUCTIONS: PLEASE RESPOND TO ALL QUESTIONS. LEAVE NOTHING BLANK. IF IT DOES NOT APPLY, ENTER "NONE". YOU WILL BE ASKED TO PROVIDE APPLICABLE DOCUMENTATION THROUGHOUT THE APPLICATION. MAKE SURE YOU VERIFY DOCUMENTS TO SEND. PLEASE SEND COPIES ONLY. NO STAPLES.**

**I. PATIENT INFORMATION**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Are you a KY resident?**  Yes  No  
**Are you in the United States on a Visa, expired or not?**  Yes  No *\*\*if yes please provide a copy of the Visa*  
**Employment Status:**  Employed  Unemployed  Self-Employed  Retired  Disabled  Student  
**Employer:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_  
**Are you considered?**  Blind  Disabled  Over the age of 65  Pregnant  Minor child or  Have minor children in the home?  N/A

**II. SPOUSE-If Married  /Parents(s) or Legal Guardian(s)-if patient is a minor  / Not applicable**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**UKHC MR#** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_ **Phone#** \_\_\_\_\_  
**Employment Status:**  Employed  Unemployed  Self-Employed  Retired  Disabled  Student  
**Employer:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**UKHC MR#** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_ **Phone#** \_\_\_\_\_  
**Employment Status:**  Employed  Unemployed  Self-Employed  Retired  Disabled  Student  
**Employer:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**III. Household Members and Income – Provide paycheck stubs/proof of income for the previous month starting with yourself and including all household members. Examples of Income types; Employment Income, Employment Pension, Social Security, Social Security Disability, Welfare Income, Unemployment Compensation, Guard/Reserve Military, Workers Compensation Benefits, Rental Income, Alimony, Interest/Dividends, Grants/Financial Aid/Scholarships**

Name of Household Member	Age/Birthdate	Relationship to Patient	Source/Type of Income & Amount 1	Source/Type of Income & Amount 2	Source/Type of Income & Amount 3
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$

The household is requested to provide copies of all bank statements for checking, savings, and/or money market accounts for the previous three (3) months OR complete the Attested Statement of No Bank Account.

	<u>Bank Name</u>	<u>Balance</u>
Checking Accounts	_____	\$ _____
Savings Accounts	_____	\$ _____
Trust Funds	_____	\$ _____
Stocks/bonds	_____	\$ _____
Money Market Accounts	_____	\$ _____
Mutual Funds	_____	\$ _____
SSI/SSDI/Social Security Debit Card	_____	\$ _____

**UKHC Financial Assistance Application**

Medical Record # if known \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Complete the Attestation Statement below for patients or households without a checking, savings, Direct Express, or Prepaid card account. Also, households must provide one month of receipts for using a check cashing service or paying utility bills in cash.**

**Attested Statement of No Bank Account (checking, savings, or debit cards for deposits-only accounts)**

This signed and attested statement document is used to verify \_\_\_\_\_ (Applicant Name) does not have a checking or savings account with any financial institution.

\_\_\_\_\_  
Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

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**I certify by signing below that the information provided on this application is true, correct, and complete to the best of my knowledge. I understand false or withheld information will result in revocation of any financial assistance adjustments and charges will become the responsibility of the patient/guarantor.**

\_\_\_\_\_  
Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

<b>For Office Use Only:</b> UK HealthCare Employee: _____	
Interpreter/Cryacom Representative Name or ID# _____	
Patient MRN# _____	
Additional Household Members:	
1. Name _____	MRN# _____
2. Name _____	MRN# _____
3. Name _____	MRN# _____
4. Name _____	MRN# _____
5. Name _____	MRN# _____
6. Name _____	MRN# _____