**Medical Record Number (if known): _____**
**Location where you received medical services (check one, if known):**
**☐ UK Lexington ☐ UK King's Daughters ☐ UK St. Claire**

**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
☐ - Government-issued photo identification. If the patient is a minor, the identification must be provided by the guarantor or parent.
☐ - Proof of income - Paycheck stubs from the past three (3) months, *or* a letter from your employer verifying your gross income (income before taxes).
☐ - Benefit verification (if applicable) - Documentation for Social Security, Disability, or Workers' Compensation benefits.
☐ - Self-employment income (if applicable) - Documentation showing your self-employment status and income.
☐ - Child support or alimony (if applicable) - Documentation showing payments you receive.
☐ - Bank statements - Checking and savings account statements for the past three (3) months. (Please note the source of each deposit on the statements.)
☐ - No income verification (if applicable) - If neither you nor your spouse has income, the person who helps pay for your daily living expenses must complete the "No Income" verification form.

**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.**