UK HealthCare
The Power of Advanced Medicine

UKHC Financial Assistance Application

Medical Record # _____

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

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: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ Are you a US Citizen? ☐ Yes ☐ No

Are you a KY resident? ☐ Yes ☐ No Are you an Ohio Resident? ☐ Yes ☐ No If resident of another state, where?

Are you in the United States on a Visa, Passport, or other type of document expired or not? ☐ Yes ☐ No ***if yes to any please provide a copy*

Employment Status: ☐Employed ☐Unemployed ☐Self-Employed ☐Retired ☐ Disabled ☐ Student

Employer: _____ Hourly Rate/Salary $ _____ (Hourly ☐ or Weekly ☐) 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 / Not applicable ☐

Name: _____ **Date of Birth**: _____ Are you a US Citizen? ☐ Yes ☐ No

UKHC MR# _____ Social Security Number: _____ Phone number: _____

Employment Status: ☐Employed ☐Unemployed ☐Self-Employed ☐Retired ☐Disabled ☐Student

Employer: _____ Hourly Rate/Salary $ _____ (Hourly ☐ or Weekly ☐) Phone number: _____

III. Parents(s)or Legal Guardian(s)-if patient is a minor / Not applicable ☐

Name: _____ **Date of Birth**: _____ Are you a US Citizen? ☐ Yes ☐ No

UKHC MR# _____ Social Security Number: _____ Phone number: _____

Employment Status: ☐Employed ☐Unemployed ☐Self-Employed ☐Retired ☐Disabled ☐Student

Employer: _____ Hourly Rate/Salary $ _____ (Hourly ☐ or Weekly ☐) Phone number: _____

Name: _____ **Date of Birth**: _____ Are you a US Citizen? ☐ Yes ☐ No

UKHC MR# _____ Social Security Number: _____ Phone number: _____

Employment Status: ☐Employed ☐Unemployed ☐Self-Employed ☐Retired ☐Disabled ☐Student

Employer: _____ Hourly Rate/Salary $ _____ (Hourly ☐ or Weekly ☐) Phone number: _____

Dependent Name	Med Rec#	SSN	DOB	US Citizen
				☐Y / ☐N
				☐Y / ☐N
				☐Y / ☐N
				☐Y / ☐N
				☐Y / ☐N
				☐Y / ☐N

IV. SOURCE OF HOUSEHOLD INCOME: Answer the following questions for you, your spouse, and dependents in your household.

	PATIENT/PARENT 1		SPOUSE/PARENT 2		DEPENDANT	
Are you currently working, or have you worked within the past six (6) months?	☐YES	☐NO	☐YES	☐NO	☐YES	☐NO
Are you receiving Unemployment or Worker's Compensation benefits?	☐YES	☐NO	☐YES	☐NO	☐YES	☐NO
Are you receiving Social Security, Veterans Administration, or Disability benefits?	☐YES	☐NO	☐YES	☐NO	☐YES	☐NO
Are you receiving Pension or Retirement benefits?	☐YES	☐NO	☐YES	☐NO	☐YES	☐NO
Are you receiving Alimony, Child Support or Kinship benefits?	☐YES	☐NO	☐YES	☐NO	☐YES	☐NO
Do you receive Rental Income?	☐YES	☐NO	☐YES	☐NO	☐YES	☐NO
Do you receive any form of income assistance from the State?	☐YES	☐NO	☐YES	☐NO	☐YES	☐NO

University of Kentucky●Patient Financial Experience Department●1000 South Limestone Room A101●Lexington, KY 40536
Phone: 855-211-4707●Fax: 859-257-8071

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RESOURCES: Provide the current, estimated value of each of your resources. If any of these do not apply to you, mark as N/A (not applicable) beside those that do not apply.

Checking Account	$	Savings Account:	$
Certificates of Deposit (CDs)	$	Stocks	$
Savings Bonds	$	Annuities	$
401K (or similar account)	$	IRA	$

Do you own any REAL ESTATE, not including your current home? ☐YES ☐NO

If **YES**, provide a short description and estimated value:

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

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.

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 Signature Date

_____ _____
Spouse/Parent/Legal Guardian Signature Relationship to Patient

Disclaimer for Financial Assistance

Approval of financial assistance does not guarantee coverage for 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, and services that are not considered an exclusion.

I certify that the information provided on this application is correct and complete to the best of my knowledge and belief. I understand that if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. Please note that all applications require a signature to be considered for processing:

_____ _____
Patient Signature **Date**

_____ _____
Spouse/Parent/Legal Guardian Signature **Relationship to Patient**

RESET

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