MR#____________________________

HealthCare
The Power of Advanced Medicine

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 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.

Required Documents

- ☐ Completed and signed Financial Assistance Application
- ☐ Proof of income for each member of the household. Household income includes the patient, spouse, or guarantor, and all household dependents 18 years of age and older as listed on the income page of the application. Household gross income and assets include wages, self-employment, social security, Veterans benefits, pension, investments, retirement, unemployment, workers' compensation, alimony, disability, rental properties, and bank accounts. Gross income is the income before taxes, insurance, and other deductions.
- ☐ If you do not have proof of income, please complete a UKHC No Proof of Income and Living Expense Statement form Part A.
  - ☐ Have the non-household member providing you with financial assistance, complete and sign Part B and Part C.
  - ☐ Have the non-household member complete and sign Part C verifying you have no income.
- ☐ Self-Employed federal and state income tax returns for the prior calendar year and Schedule C of their federal income tax return or quarterly profit/loss statement.
- ☐ Bank statements for the previous three months are required. If your application is completed in April, you must provide January, February, and March bank statements to comply with the requirements. It must be in bank statement format, showing the beginning balance, transactions, and ending balance. Include all pages of the statement.

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	$20,782.80	$30,120.00	$45,180.00
2	$20,440.00	$28,207.20	$40,880.00	$61,320.00
3	$25,820.00	$35,631.60	$51,640.00	$77,460.00
4	$31,200.00	$43,056.00	$62,400.00	$93,600.00
5	$36,580.00	$50,480.40	$73,160.00	$109,740.00
6	$41,960.00	$57,904.80	$83,920.00	$125,880.00
7	$47,340.00	$65,329.20	$94,680.00	$142,020.00
8	$52,720.00	$72,753.60	$105,440.00	$158,160.00

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UKHC Financial Assistance Application
Solicitud de Asistencia Financiera de UKHC

INSTRUCTIONS: PLEASE RESPOND TO ALL QUESTIONS. LEAVE NOTHING BLANK. IF IT DOES NOT APPLY, ENTER "NONE". YOU WILL BE ASKED TO PROVIDE APPLICABLE DOCUMENTATION THROUGH OUT THE APPLICATION. MAKE SURE YOU VERIFY DOCUMENTS TO SEND. PLEASE SEND COPIES ONLY. NO STAPLES.
INSTRUCCIONES: POR FAVOR RESPONDA TODAS LAS PREGUNTAS EN ESTA APLICACIÓN. NO DEJE NADA EN BLANCO. SI ALGUNA PREGUNTA NO CORRESPONDE HA USTED, POR FAVOR PONGA "N/A" SE LE PEDIRÁ QUE PROPORCIONE LA DOCUMENTACIÓN CORRESPONDIENTE A LO LARGO DE LA APLICACIÓN. ASEGURESE DE VERIFICAR LOS DOCUMENTOS QUE MANDE POR CORREO. SOLAMENTE MANDE COPIAS SIN GRAPAS.

I. PATIENT INFORMATION(INFORMACIÓN PARA EL PACIENTE)

Patient Name(Nombre del paciente):____ **Date of Birth(Fecha de Nacimiento):** _______________

Address(Dirección):____ Social Security Number(Número de seguro social): ____________

City(Ciudad):______________________ State(Estado):_______ Zip Code(Código postal): ____________

Home Phone(Teléfono residencial): ______________________ Cell Phone(Teléfono celular): ______________________

Are you a KY resident(¿Eres residente de KY)? ☐Yes(Sí) ☐No(No)

Are you in the United States on a Visa, expired or not(¿Está usted en los Estados Unidos con una Visa, vencida o no)?
☐ Yes(Sí) ☐ No(No) - If yes, is it a(Si es así, ¿es un) ☐Work(Trabajo) or(o) ☐Traveling Visa(Visado de viaje)?
***Must provide a copy of the Visa(Debe proporcionar una copia de la Visa)*

Employment Status(Situación laboral):
☐Employed(Empleado) ☐Unemployed(Desempleado) ☐Self-Employed(Autónomo) ☐Retired(Jubilado) ☐Disabled(Deshabilitado) ☐Student(Estudiante)

Employer(Empleador) ____ Phone Number(Número de teléfono) __________________

Are you considered(¿Te consideran)? ☐Blind(Ciego), ☐Disabled(Deshabilitado), ☐Over the age of 65(Mayores de 65 años), ☐Pregnant(Embarazada), ☐Minor child or(Menor de edad o) ☐Have minor children in the home(Tener hijos menores de edad en el hogar)? ☐ N/A

II. SPOUSE-If Married(Esposa(o)-si estata casada(o))☐/Parents(s) or Legal Guardian(s)-if patient is a minor(Padres o Guardián-si el paciente es menor)☐/ Not applicable(no applicable)☐

Name(Nombre):____ **Date of Birth(Fecha de Nacimiento):**_______________

UKHC MR# __________________ Social Security Number(Número de seguro social): __________ Phone(Teléfono)# __________________

Employment Status(Situación laboral):
☐Employed(Empleado) ☐Unemployed(Desempleado) ☐Self-Employed(Autónomo) ☐Retired(Jubilado) ☐Disabled(Deshabilitado) ☐Student(Estudiante)

Employer(Empleador) ____ Phone Number(Número de teléfono) __________________

Name(Nombre):____ **Date of Birth(Fecha de Nacimiento)** _______________

UKHC MR# __________________ Social Security Number(Número de seguro social): __________ Phone(Teléfono)# __________________

Employment Status(Situación laboral):
☐Employed(Empleado) ☐Unemployed(Desempleado) ☐Self-Employed(Autónomo) ☐Retired(Jubilado) ☐Disabled(Deshabilitado) ☐Student(Estudiante)

Employer(Empleador) ____ Phone Number(Número de teléfono) __________________

III. Additional Family Members(Miembros adicionales de la familia)

	Name (Nombre)	Social Security Number (Número de Seguro Social)	Age (Edad)	Birthdate (Fecha de nacimiento)	Relationship (Relación)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

IV. Additional Income – Please provide paycheck stubs/proof of Income for the previous three months. (Ingresos adicionales - Proporcione talones de cheques de pago/comprobantes de ingresos de los últimos tres meses.)

	Monthly Amount (Monto Mensual)
Employment income - Patient/Guardian 1 (Ingresos laborales - Paciente/Tutor 1)	$ ____________
Employment income - Spouse/Guardian 2 (Ingresos laborales - Cónyuge/Tutor 2)	$ ____________
Retirement/Social Security (Jubilación/Seguridad Social)	$ ____________
Pension (Pensión)	$ ____________
VA Benefits (VA Benefits)	$ ____________
Child Support(Manutención de los hijos)	$ ____________
Unemployment compensation (Compensación por desempleo)	$ ____________
Self-Employment(Trabajo por cuenta propia) (quarterly profit/loss statement required) (se requiere un estado de pérdidas y ganancias trimestral)	$ ____________
Guard/Reserves/Military (Guardia / Reservas / Militares)	$ ____________
Workers Comp Benefits (Beneficios de Compensación para Trabajadores)	$ ____________
Rental Property or Lease (Propiedad de alquiler o arrendamiento)	$ ____________
Alimony(Manutención del esposo)	$ ____________
AFDC/TANF/Welfare (AFDC/TANF/Bienestar)	$ ____________
Interest / Dividends(Intereses / Dividendos)	$ ____________
Grants/Financial Aid/Scholarships (Subvenciones/Ayuda Financiera/Becas)	$ ____________
Other Income – Spouse/Gardian 2 Specify Type of Income - ____________________ Otros ingresos – Paciente/Tutor 2 Especificar tipo de ingreso - __________________	$ ____________

Total Monthly Income(Ingreso mensual total) **$________________________**

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

UK HealthCare
The Power of Advanced Medicine

Financial Assistance Application
Solicitud de Asistencia Financiera

Patient Name(Nombre del paciente):___________________________________ **Birth date(Fecha de nacimiento):_____________**

V. Assets/Resources
NOTE: Bank statements and /or Debit Card statements that reflect income deposits are required for the previous three months for the household for financial assistance consideration. Example: If your application is completed in April, you must provide January, February, and March bank statements to comply with the requirements. It must be in bank statement format, showing the beginning balance, transactions, and ending balance. Include all pages of the statement. (Activos/Recursos NOTA: Se requieren estados de cuenta bancarios y/o estados de cuenta de tarjetas de débito que reflejen depósitos de ingresos de los últimos tres meses para el hogar para la consideración de asistencia financiera. Ejemplo: Si su solicitud se completa en abril, debe proporcionar estados de cuenta bancarios de enero, febrero y marzo para cumplir con los requisitos. Debe estar en formato de extracto bancario, mostrando el saldo inicial, las transacciones y el saldo final. Incluya todas las páginas de la declaración.)

Do the patient/guarantor/spouse have a checking and/or savings account(¿Tiene el paciente/garante/cónyuge una cuenta corriente y/o de ahorros)?
☐Yes(Sí) ☐No(No), if yes; include bank statements for all accounts(En caso afirmativo; Incluir estados de cuenta bancarios para todas las cuentas)

	Bank Name Nombre del banco	Balance Equilibrar
Checking Accounts(Cuentas de cheques)	__________________________	$________________
Savings Accounts(Cuentas de ahorro)	__________________________	$________________
Trust Funds(Fondos fiduciarios)	__________________________	$________________
Stocks/bonds(Acciones/bonos)	__________________________	$________________
Money Market Accounts(Cuentas del mercado monetario)	__________________________	$________________
Mutual Funds(Fondos Mutuos)	__________________________	$________________

____ ____________

Patient Signature(Firma del paciente) **Date (Fecha)**

____ ___________________

Signature of Legal Representative **Relationship to patient**
(Firma del Representante Legal) **(Relación con el paciente)**

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UK HealthCare Employee: __________

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