



## **Jennie Stuart Medical Center Financial Assistance**

Thank you for choosing Jennie Stuart Medical Center for your healthcare needs! We are pleased to provide you with the enclosed application to determine if you are eligible for financial assistance. In order for us to process your application, the information requested on the enclosed Financial Disclosure document must be completed in its entirety. Please be assured that the information you provide will be treated confidentially and will only be used to determine whether financial assistance can be provided to you.

It is required that you submit all applicable documentation listed below. All pages of all documents are required and no altered documents will be accepted. If Federal Income Tax guidelines require you to complete a tax return, that return must be completed before financial assistance can be considered. Failure to provide all requested information may cause your application to be denied. Falsification of any kind may result in permanent denial for hospital financial assistance. You must exhaust all forms of state assistance before qualifying for hospital assistance. The required documents are as follows:

- Identification documentation such as driver's license, US passport, or other photo ID
- Fully completed and signed Financial Assistance application.
- Copy of most recent tax return
- Proof of income for all wage earners in household (one of the following):
  - Copies of the three (3) most recent pay stubs (year-to-date gross)
  - Most recent Social Security, disability, worker's compensation, unemployment, pensions, and any other form of income documents
  - If \$0 income, provide a statement on how you are supporting yourself financially
- Copy of current bank statements from all accounts, including any supporting documentation claiming the source of each deposit not covered by income above.
  - All applications without bank statements must provide one month of check cashing service or utility bills paid in cash.
- Two most recent investment statements from all accounts not covered by the above such as HSA, FSA, Stocks, Bonds, CD, excluding retirement accounts
- Evidence of Medicaid application or lack of eligibility. Full cooperation with our staff or contractor will be acceptable evidence.

Our Financial Counselors are available Monday through Friday from 7:00 AM until 3:30 PM to discuss the application process at 270-887-0332 or 270-887-0100 ext. 4505.

For a free copy of our Financial Assistance Guidelines, Policy, and Application, visit our website at [www.jenniestuarthealth.org](http://www.jenniestuarthealth.org) on the Patients & Visitors tab. Policies and applications are offered in both English and Spanish, and Jennie Stuart Medical Center offers translation services to assist patients who speak a language other than English.



Health

## FINANCIAL ASSISTANCE APPLICATION

ACCOUNT INFORMATION			
Date of Visit:		Location of Visit:	

PATIENT INFORMATION	
Account Number:	
Patient Name:	
Patient SSN:	
Patient DOB:	
Patient Phone:	
Patient Address:	
Patient Employer:	
Occupation:	
Work Phone:	

GUARANTOR/SPOUSE INFORMATION	
Relation to Patient:	
Name:	
SSN:	
DOB:	
Phone:	
Guarantor/Spouse Address:	
Employer:	
Occupation:	
Work Phone:	

HOUSEHOLD MEMBER INFORMATION			
Household Member (spouse and/or dependents under 18)	Age	SSN	Relationship to Patient
1			
2			
3			
4			
5			
6			
7			
8			

MONTHLY HOUSEHOLD INCOME				
SOURCE	SELF	SPOUSE	OTHER*	TOTAL
Employment/Self-Employment Income				
Retirement/Pension/Social Security				
Unemployment/Work Comp/Disability				
Dividends/Interest/Rental Income				
Child Support/Alimony				
Other Income (describe below)				
<b>Total Monthly Gross Income</b>				
<b>Annual Income = (A x 12)</b>				
Annual Income Adjustments (describe)				
Total Annual Income Adjustments				
<b>Adjusted Annual Income = (B + C)</b>				

A  
B  
C  
D

\*Include information on all wage earners in household. Attach additional pages if necessary.

<b>ASSETS*</b>			
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Bank Name	Account #	Checking/Savings	Current Balance

E  
E  
E

Stocks, CDs, or other investments	Account #	Type of Investment	Current Balance

E

Life Insurance or Burial Plan	Policy Amount	Type	Cash Value

E

Home (Primary Residence)	Market Value	Mortg/Loan Balance	Equity Value

E

Other Property (such as vehicles, boats, equipment, rental property, land, etc...)	Market Value	Loan Balance	Equity Value

E  
E  
E

<b>Total Assets = (sum of E)</b>	
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F

<b>Total Household Resources = (D + F)</b>	
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**COMMENTS/DESCRIPTIONS:** \_\_\_\_\_

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I certify that all information on this application is correct and complete to the best of my knowledge and belief. I understand and agree that if JSMC learns that I have made false statements on this application, it may seek legal action against me to recover the costs of services and attorney fees. I authorize JSMC to obtain a consumer report, including a credit report, on me and I understand that if it is used in making an adverse decision regarding my application, JSMC will provide me with a copy of the report, and I will be given a written description of my rights under the Federal Fair Credit Reporting Act.

<b>Applicant Signature:</b>		<b>Date:</b>	
<b>Name of Individual Completing Form:</b>		<b>Relation to Patient:</b>	
<b>JSMC Signature:</b>		<b>Date:</b>	

\*Include information on all wage earners in household. Attach additional pages if necessary.