

Dear Valued UK King's Daughters Patient:

UK King's Daughters offers financial assistance to cover the out-of-pocket expenses for qualifying patients. Eligibility for assistance depends on your prompt return of the application and the Income Verification Information listed below. You may also be asked to complete applications and provide information for other programs which are offered by local, state, or federal agencies. Refusal to respond to these requests may affect the status of this application.

Income Verification Information

Send all of the information below that applies to you, or any other member of your household.

- Pay check stubs for the past three (3) months, or a letter from your employer to verify your gross income
- Verification of Social Security, Disability, or Worker's Compensation benefits
- Verification of Unemployment, Retirement, or Pension benefits
- Verification of Self-employment status and income
- Verification of Child Support or Alimony payments
- A copy of **ALL** forms filed with your Federal Income Taxes for the previous year, including W2's
- A copy of your bank statements (checking and savings) from the past three (3) months, noting next to each deposit the source of funds for that deposit
- If neither you nor your spouse have a source of income, you will need to have the person who is helping to supply your daily living expenses complete the "NO INCOME" verification form.
- If you and your spouse are currently separated and maintaining separate households, you may apply without including his/her income. To do so, you will need to have a non-relative complete and sign the attached "STATEMENT OF SEPARATION" form.

If you have questions, would like to schedule an appointment, or need to return your completed application and verification information, you may contact us by the following methods:

By Phone: 606-408-4118 or 866-408-6466
By Fax: 606-408-6917
By E-mail: FinancialAssistanceTeam@kdmc.net

By Mail: UK King's Daughters
PO Box 151
Ashland, KY 41105

Please allow adequate time for the processing of your completed application. After processing is complete you will receive a letter to explain your approval or the reason for denial.

Sincerely,

Financial Assistance Representative

FINANCIAL ASSISTANCE APPLICATION



PATIENT or RESPONSIBLE PARTY: _____ **SSN:** _____ - _____ - _____ **DOB:** (____ / ____ / ____)

ADDRESS: _____ **CITY:** _____ **ST:** _____ **ZIP:** _____.

E-mail: _____ **MARITAL STATUS:** _____

PHONE NUMBERS: (HOME) _____ **(CELL)** _____ **(WORK)** _____

Please, list any other members of your immediate household (spouse; minor, dependant children; or full-time students over 18 years old)

Spouse's Name: _____ SSN: _____ - _____ - _____ DOB: (____ / ____ / ____)

Child/Dependant: _____ SSN: _____ - _____ - _____ DOB: (____ / ____ / ____)

Child/Dependant: _____ SSN: _____ - _____ - _____ DOB: (____ / ____ / ____)

Child/Dependant: _____ SSN: _____ - _____ - _____ DOB: (____ / ____ / ____)

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

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

RESOURCES: Provide the current, estimated value of each of your resources.

Checking Account \$ _____ Savings Account \$ _____
Certificates of Deposit (CDs) \$ _____ Stocks \$ _____
Savings Bonds \$ _____ Annuities \$ _____
401k (or similar account) \$ _____ IRA \$ _____

How many cars are owned by you, your spouse, and dependants? _____ What is the total estimated value \$ _____

Do you own any REAL ESTATE, not including your current home? YES NO
If YES, provide a short description and estimated value: _____

Is the reason for your visit related to an illness, injury, or condition that was caused by the negligence of another person? YES NO
If YES, please provide a brief explanation: _____

I understand and agree that the information in this form will be relied upon in determining my eligibility for financial assistance and that incorrect, incomplete or misleading information may result in the denial or rescission of financial assistance. I further understand and agree that I have a duty to supplement the information contained in this form in the event a material change in my financial circumstances takes place prior to the final determination of my eligibility for financial assistance.

Applicant's Signature: _____ **Date** _____