Owensboro Health

FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS

1. Complete the financial assistance application.
2. Include all monthly income and expenses in the spaces provided.
3. Provide proof of income, including:
   a) Last 2 pay stubs AND most recent filed W-2;
   b) Most Recent Tax Returns;
   c) Attestation Letter;
   d) Current Benefit awards letters showing Social Security, SNAP (Food Stamps), Disability, Worker's Compensation, or Veteran's Administration benefits;
   e) Copies of current benefit award letters or 1099 forms showing Unemployment, Retirement*, or Pension benefits;
   f) Proof of Assets which may include, but not limited to complete copies of monthly checking, savings, investments, Venmo, Chime, PayPal, holdings, and retirement accounts for most recent three months;
   g) Verification of self-employment status and income received:

      Receipts from clients,
      Signed Federal income taxes from the most recent filing year which include the appropriate schedule showing income from self-employment, S-corp, or other such entity.
4. Sign the financial assistance application.

If you have no income, you will need to provide an explanation for how you meet your daily living expenses.

*If you have questions or need assistance completing this application, please call (270) 685-7501 or visit the Business Office, located at 2511 Frederica St. Owensboro KY 42301, Monday through Friday, 8:00 a.m. to 4:30 p.m. Or you can email us at financialassistance@owensborohealth.org**.**

Mail or Fax the completed application and documents to:
270-685-7560
Owensboro Health
PO Box 20007
Owensboro, KY 42304
Attn: Patient Financial Advocate

Once we have received all of the information and documentation requested, we will make and notify you by mail of your eligibility for participation in the Financial Assistance Program within 30 days.

Owensboro Health

Responsible Party Name:_____ Date of Birth:_____ SSN:_____
Address:_____ Phone:_____
_____ Marital Status per Federal Tax Return:_____
Spouse Name:_____ Spouse Date of Birth:_____ Spouse SSN:_____
Primary Insurance:_____ ID #:_____ Insured Person:_____
Secondary Insurance:_____ ID #:_____ Insured Person:_____

Household (Dependent) Member's Name **Relationship** **SSN** **Age**

_____
_____
_____
(Use back of page for additional Household Member's) Number of people in the household (including patient)_____

EMPLOYMENT:
Employer_____ Length of Employment or Hire Date:_____
Spouse Employer _____ Spouse Length of Employment or Hire Date:_____

GROSS INCOME:		Monthly ($)
Responsible party or patient's gross wages from paychecks/W2s……		_____
Spouse's and any children's gross wages from paychecks/W2s……		_____
Alimony:……		_____
Social Security: ……		_____
SSI/Disability/K-Tap:……		_____
Unemployment: …… ……		_____
Pension: ……		_____
Food Stamps: ……		_____
Other Income (e.g., Investment, Workers' Comp.): Yes/No (circle one)		
If yes, list: _____		_____
TOTAL MONTHLY INCOME: ……	$	_____

EXPENSES:		
Rent/Mortgage: ……	$	_____
Food and Supplies:……		_____
Utilities:……		_____
Telephone:……		_____
Childcare: ……		_____
Insurance Premiums (auto, health, dental, life, home, etc.):……		_____
Prescribed Medications:……		_____
Other Expenses? Yes/No (circle one)		
If yes, list: _____		_____
TOTAL MONTHLY EXPENSES: ……	$	_____

RESOURCES:		
Total # of Checking Accounts_____ Saving Accounts_____	$	_____
Stocks and Bond Values:……	$	_____
Real Estate other than primary residence: Value_____ Balance Owed_____		
Other resources? Yes/No (circle one) If yes, list: _____		_____
TOTAL RESOURCES: ……	$	_____

I certify that the information provided by me in this application is correct and true to the best of my knowledge and belief. I understand that if I give false information or withhold information in applying for assistance, my application may be denied and Owensboro Health may pursue collection of any outstanding balance due. In that instance, I may also be subject to prosecution for fraud. I agree to notify OH of any changes to the information provided in this form including address, telephone number, and income.

_____ _____
(RESPONSIBLE PARTY SIGNATURE) **(DATE)**

_____ _____
(SPOUSE SIGNATURE) **(DATE)**

OFFICE USE ONLY

Discount % Approved _____
Date Submitted _____
FC Signature _____
Approval Signature _____
Date Approved _____

Revised 2/3/2023

PLAIN LANGUAGE SUMMARY

Owensboro Health ("OH") offers financial assistance to patients with no health insurance, or those who have out-of-pocket responsibilities that they cannot afford even after insurance has paid for a portion of their care. Patients must submit an application for financial assistance and all required supporting documentation, demonstrating financial need and must otherwise comply with the requirements of the hospital's Financial Assistance Policy.

The Financial Assistance Program application, policy, and Plain Language Summary may be found on the Hospital's website. Alternatively, printed copies of the Hospital's Financial Assistance Policy, the Plain Language Summary, or the application form can be obtained for free by visiting or calling the Hospital's Patient Financial Services. You may contact the Patient Financial Services office to discuss any questions you might have. This Plain Language Summary will be made available in both English and Spanish. If additional documents are needed, we will contact you by phone or mail to let you know what else is required.

If you are uninsured, you will generally qualify for free Emergency and other Medically Necessary Care under OH's Financial Assistance Program (1) if you have an annual household income equal to or less than 300% of the Federal Poverty Level, (2) lack any other assets to pay for your charges and (3) if requested to do so by OH, you apply for Medicaid or other state or Federal programs and fully cooperate in the application and determination process.

If you are uninsured or have a balance remaining after insurance, you will generally qualify for discounted Emergency and other Medically Necessary Care under OH's Financial Assistance Program (1) if you have household income of up to 400% of the Federal Poverty Level, (2) lack any other assets to pay for the amounts for which you become personally responsible for paying, and (3) if requested to do so by OH, apply for Medicaid or other state or Federal programs and fully cooperate in the application and determination process.

If OH determines that you are eligible for financial assistance, you will not be personally responsible for paying more than the amount we generally bill patients having insurance coverage for the same care. In addition, you will never be required to make advance payments or other payment arrangements to receive emergency services. However, you may be required in most situations to make a substantial advance deposit or agree to other payment arrangements before receiving non-emergency services.

Free copies of this summary, the Financial Assistance Policy, the Billing and Collections Policy, and the Financial Assistance Program application, including Spanish translations, are available on OH's website at http://www.owensborohealth.org/patient-visitor/about-your-stay/billing/financial-assistance/ . Copies are also available at the Hospital in the Admitting areas located near the main entrances or Patient Financial Advocate area. This information is also available by mail by contacting OH Customer Service at 270-685-7500.

OH's Patient Financial Advocate staff is available to answer questions and provide information about the Financial Assistance Program and assistance with the application process. Our Patient Financial Advocate staff is located throughout our clinics, Hospitals, and the Business Center (located at 2511 Frederica Street, Owensboro, Kentucky 42301). They can also be reached by phone at 270-685-7500 or via email financialassistance@owensborohealth.org.