James B. Haggin Memorial Hospital

Haggin's Commitment: Quality and Caring

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name: _____

Patient Account Number(s) _____

The James B. Haggin Memorial Hospital has a Financial Assistance Program for patients who meet certain financial criteria and are unable to meet the credit policies of the hospital.

To apply for our Financial Assistance Program, you must provide the following items to the Business Office.

1 The financial summary sheet.
2 The most recent completed federal tax form filed by applicant.
3 The most recent three (3) months of pay stubs for every person working in the family.
4 Any award letters from any government or other agency that shows income that has been awarded to the individual.
5 Any pension or other retirement statement that proves income of the individual.
6 A signed and/or notarized no income attestation from someone that can verify the income status of the indivi

The James B. Haggin Memorial Hospital discount guidelines for uninsured/underinsured based on 2017 Federal Poverty Guidelines.

Family Size	% of Poverty Lvl.> Disc. %>	100% 100%	150% 90%	200% 80%	250% 70%	300% 60%		Resource Limit
1		$12,060	$18,090	$24,120	$30,150	$36,180		$2,000
2		$16,240	$24,360	$32,480	$40,600	$48,720		$4,000
3		$20,420	$30,630	$40,840	$51,050	$61,260		$4,050
4		$24,600	$36,900	$49,200	$61,500	$73,800		$4,100
5		$28,780	$43,170	$57,560	$71,950	$86,340		$4,150
6		$32,960	$49,440	$65,920	$82,400	$98,880		$4,200

Add an additional $4,180 for each person

I certify that the information I have provided on this application is true and correct.

SIGNATURE (PERSON MAKING REQUEST): _____

DATE: _____

Return all of the requested forms to:

The James B. Haggin Memorial Hospital
Attn: Lillian Frederick
464 Linden Ave.
Harrodsburg, Ky., 40330

If you have any questions, please call (859)733-4874

THE JAMES B. HAGGIN MEMORIAL HOSPITAL

APPLICATION FOR FINANCIAL ASSISTANCE

FINANCIAL SUMMARY SHEET

PATIENT INFORMATION

Responsible Party Name: _____ Date of Birth: _____ SS #: _____

Relationship to Patient _____ Phone#(Home) _____ Work #: _____

Address _____ Marital Status: _____

_____

Spouse's Name _____ Date of Birth: _____ SS #: _____

Primary Insurance _____ ID # _____ Insured Person _____

Secondary Insurance _____ ID # _____ Insured Person _____

HOUSEHOLD MEMBER'S NAMES:

PERSON'S NAME	AGE	RELATIONSHIP TO PATIENT	SS #:

EMPLOYMENT:

Employer _____ Phone# _____

Spouse Employer _____ Phone# _____

INCOME

Your monthly take home pay: _____ Spouse's monthly take home pay: _____

Other Income sources: Retirement: _____ **COUNTABLE RESOURCES:**

Disability _____ Stocks: _____

Child Support _____ Bonds: _____

Rental Property: _____ Checking/Savings: _____

Other: _____ Other _____

Total Monthly Income: _____ Total Countable Resouces: _____